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State Resources And Services Related to Alcohol and Other Drug Abuse Problems

Fiscal Year 1989

An Analysis of State Alcohol and Drug Abuse Profile Data

August 1990

A Report for the
National Institute on Alcohol Abuse and Alcoholism
and the
National Institute on Drug Abuse

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by
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A Report for the
National Institute on Alcohol Abuse and Alcoholism
and the
National Institute on Drug Abuse

STATE ALCOHOL AND DRUG ABUSE AGENCY DIRECTORS
AND CONTACT PERSONS FOR THE
1989 STATE ALCOHOL AND DRUG ABUSE PROFILE (SADAP)

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TABLE OF CONTENTS

		Page
HIGHLIGHTS		i
EXECUTIVE SUMMARY		iv
I.	INTRODUCTION	1
II.	STUDY PURPOSE AND METHODOLOGY	4
III.	FUNDING OF ALCOHOL AND OTHER DRUG SERVICES	6
	1. Financial Expenditures by State and Funding Source	6
	2. Financial Expenditures by State and Type of Program Activity	9
	3. Comparison of Financial Expenditures for Fiscal Years 1985, 1986, 1987, 1988 and 1989 by State, Type of Program Activity, Total Expenditures and Funding Source	9
	4. Total Number and Percent of Treatment Units That Received Funds Administered by the State Alcohol/Drug Agency in Fiscal Year 1989	14
	5. Information on Medicaid Reimbursement	17
IV.	CLIENT ADMISSIONS TO ALCOHOL AND OTHER DRUG TREATMENT SERVICES	19
	1. Alcohol and Other Drug Client Admissions Data by Environment and Type of Care	20
	2. Alcohol Client Admissions Data by Sex, Age, Race/Ethnicity and Dual Addiction Problems	24
	3. Drug Client Admissions Data by Sex, Age, Race/Ethnicity and Dual Addiction Problems	32
	4. Client Admissions Data by Primary Drug of Abuse	37

		Page
	5. Comparisons of Client Admissions Data for Fiscal Years 1985, 1986, 1987, 1988 and 1989	40
	a. Comparisons of Alcohol Client Admissions Data	43
	b. Comparisons of Drug Client Admissions Data	43
V.	INTRAVENOUS (IV) DRUG ABUSE	46
VI.	STATE MODEL PRODUCT AVAILABILITY	48
VII.	TOP THREE POLICY ISSUES FROM A STATE ALCOHOL AND DRUG AGENCY PERSPECTIVE	50
	1. Treatment Services Systems	50
	2. Services to Special Populations, Including Persons with HIV and AIDS	50
	3. Administration and Staffing	54
	4. Funding and Resource Allocation	54
	5. Prevention and Treatment Services for Youth	55
VIII.	MAJOR NEEDS FOR WHICH RESOURCES WERE NOT ADEQUATE IN FISCAL YEAR 1989	56
	1. Youth and Women	57
	2. Other Special Populations	58
	3. Staff Positions, Training and Salaries	58
	4. Prevention and Early Intervention	59
	5. "Special" State Needs: Site Renovation, Remodeling, and Location; and Assistance in Data Collection	59

		Page
XI.	SIGNIFICANT CHANGES IN ALCOHOL AND OTHER DRUG PREVENTION AND TREATMENT SERVICES IN FISCAL YEAR 1989	60
	1. New Programs and Services for AIDS and IV Drug User Populations	60
	2. Client and Drug Use Trends	61
	3. Changes in Financial Resources	62
	4. Changes in Services and Programs for Youth	64
	5. Prevention Programs and Services	64
	6. Changes in Admissions to Treatment	65
	7. Other Significant Developments	66
X.	RESPONSES TO SPECIAL QUESTIONS	69
	1. Issues and Concerns Relating to Measurement of Access to Appropriate Care/Waiting Lists/Continuum of Care Services	69
	2. Problems Experienced by Pregnant Women in Accessing Care for Alcohol and/or Other Drug Problems	71
	3. State Needs for Additional Program Staff	73
	4. Information on Alcohol and Other Drug Exposed Babies	74

LIST OF TABLES

TABLES		PAGE
1.	Expenditures for State-Supported Alcohol and Other Drug Abuse Services by State and by Funding Source for Fiscal Year 1989	8
2.	Expenditures for State-Supported Alcohol and Other Drug Abuse Services by State and by Type of Program Activity for Fiscal Year 1989	10
3.	Expenditures for State-Supported Alcohol and Other Drug Abuse Services by State for Fiscal Years 1985, 1986, 1987, 1988 and 1989	12
4.	Comparison of Expenditures for Alcohol and Other Drug Abuse Services by Funding Source for Fiscal Years 1985, 1986, 1987, 1988 and 1989	13
5.	Comparison of Expenditures for Alcohol and Other Drug Abuse Services by Type of Program Activity for Fiscal Years 1985, 1986, 1987, 1988 and 1989	13
6.	Number of Alcohol and/or Drug Treatment Units Which Received Funds Administered by the State Alcohol/Drug Agency for Fiscal Year 1989	15
7.	Estimate of Percent of Total Alcohol and/or Drug Treatment Units in Each State that Received Any Funds Administered by the State Alcohol/Drug Agency for Fiscal Year 1989	16
8.	Status of Medicaid Reimbursement for Alcohol and Other Drug Services by State for Fiscal Year 1989	18
9.	Number of Alcohol and Other Drug Client Treatment Admissions by State for Fiscal Year 1989	21
10.	Number of Alcohol and Other Drug Client Treatment Admissions by Type of Environment, Type of Care and State for Fiscal Year 1989	22
11.	Number of Alcohol Client Treatment Admissions by Sex and State for Fiscal Year 1989	25
12.	Number of Alcohol Client Treatment Admissions by Age and State for Fiscal Year 1989	26

		PAGE
13.	Number of Alcohol Client Treatment Admissions by Age, by Sex and by State for Fiscal Year 1989	28
14.	Number of Alcohol Client Treatment Admissions by Race/Ethnicity and State for Fiscal Year 1989	30
15.	Estimated Percent of Alcohol Client Admissions Who Have Secondary Other Drug Problems	31
16.	Number of Drug Client Treatment Admissions by Sex and State for Fiscal Year 1989	33
17.	Number of Drug Client Treatment Admissions by Age and State for Fiscal Year 1989	34
18.	Number of Drug Client Treatment Admissions by Age, by Sex and by State for Fiscal Year 1989	35
19.	Number of Drug Client Treatment Admissions by Race/Ethnicity and State for Fiscal Year 1989	38
20.	Estimated Percent of Drug Client Admissions Who Have Secondary Alcohol Problems	39
21.	Number of Drug Client Treatment Admissions in State-Supported Facilities by Primary Drug of Abuse and State for Fiscal Year 1989	41
22.	Estimates of Intravenous (IV) Drug Abuser Client Treatment Admissions to State Funded and Non-State Funded Programs and Estimates of Total IV Abusers by State for Fiscal Year 1989	47
23.	Top Three Policy Issues by State Alcohol and Drug Agencies	51

LIST OF EXHIBITS

Figure		Page
1.	Expenditures for State-Supported Alcohol and Drug Abuse Services by Funding Source for Fiscal Year 1989	v
2.	Expenditures for State-Supported Alcohol and Drug Abuse Services by Type of Program Activity for Fiscal Year 1989	vii
3.	Comparison of Expenditures for State-Supported Alcohol and Drug Abuse Services by Funding Source for Fiscal Years 1985, 1986, 1987, 1988 and 1989	viii

APPENDICES

A.	STATE ALCOHOL AND DRUG ABUSE PROFILE COVER LETTER, INFORMATION COLLECTION FORMAT AND GLOSSARY OF TERMS	A-1
B.	STATE-BY-STATE POPULATION, PER CAPITA INCOME, POPULATION DENSITY AND STATE REVENUE FIGURES	B-1
C.	STATE MODEL PRODUCTS AVAILABLE AND CONTACT PERSONS	C-1
D.	STATE NARRATIVE REPORTS ON MAJOR UNMET NEEDS	D-1
E.	STATE NARRATIVE REPORTS OF SIGNIFICANT CHANGES IN SERVICES DURING FISCAL YEAR 1989	E-1
F.	STATE NARRATIVE REPORTS ON ISSUES AND CONCERNS RELATING TO MEASUREMENT OF ACCESS TO APPROPRIATE CARE/WAITING LISTS/ CONTINUUM OF CARE SERVICES	F-1
G.	STATE NARRATIVE REPORTS OF PROBLEMS IN ACCESSING CARE FOR ALCOHOL AND/OR OTHER DRUG ABUSING PREGNANT WOMEN	G-1
H.	STATE NARRATIVE REPORTS OF INFORMATION ON ALCOHOL AND OTHER DRUG EXPOSED BABIES	H-1

HIGHLIGHTS

The State Alcohol and Drug Abuse Agencies voluntarily submit a broad spectrum of fiscal, client and other service data on an annual basis to the National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD). These data are submitted via the State Alcohol and Drug Abuse Profile (SADAP) data collection effort. With financial support from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA), NASADAD staff have prepared a detailed analysis of these data. The findings for Fiscal Year (FY) 1989 as reported by the States and analyzed by NASADAD follow.

The financial and client data provided by the State Alcohol and Drug Abuse Agencies are included "for only those programs received at least some funds administered by the State Alcohol/Drug Agency." Forty-nine States, the District of Columbia, Guam and Puerto Rico participated in the FY 1989 State Alcohol and Drug Abuse Profile (SADAP).

Highlights from the FY 1989 SADAP study indicate that:

- Expenditures for alcohol and other drug abuse treatment and prevention services totaled over $2.4 billion.

- Of the total expenditures, States provided $1.1 billion or 47.1 percent, while Federal sources provided $644.5 million or 26.7 percent, county or local sources contributed $191.8 million or 7.9 percent and other sources (e.g., private health insurance, court fines, client fees or assessments for treatment imposed on intoxicated drivers) contributed $440.1 million or 18.2 percent.

- Approximately 76.9 percent of the total monies were expended for treatment services; 14.6 percent for prevention services; and 8.6 percent for other activities (e.g., training, research, administration).

- Since 1985, the average total increase in expenditures for State-supported alcohol and other drug abuse services was 76.2 percent.

- A total 7,150 alcohol and/or drug treatment units received funds administered by the State Alcohol and Drug Abuse Agencies in FY 1989. Of the total units, 1,449 were identified as alcohol units, 1,240 as drug units and 4,461 were identified as combined alcohol/drug treatment units.

- The total alcohol and other drug client treatment admissions reported by 48 States, the District of Columbia, Guam and Puerto Rico were over 1.8 million; alcohol client admissions were 77.5 percent male; 32.0 percent between the ages of 25-34; and 69.7 percent White, 17.2 percent Black and 6.4 percent Hispanic.

- A total of 48 States, the District of Columbia, Guam and Puerto Rico reported total drug client admissions of 605,914; drug client admissions were 65.7 percent male; 20.4 percent under the age of 21; 52.6 percent White; 28.4 percent Black; and 10.2 percent Hispanic.

- For the second consecutive year, cocaine was identified in overall reporting as the leading primary illicit drug of abuse with 210,869 admissions. Previously, heroin had been the leading primary illicit drug of abuse.

- For the fourth time, States were asked to provide estimates relating to intravenous (IV) drug abuse. Estimates of the number of IV drug abuser client treatment admissions to State funded programs as reported by 50 respondents, ranged from a high of 35,297 in California to a low of 26 in North Dakota and 2 in Guam. The total number of IV drug abuser client admissions to State funded programs identified was 186,805.

- A total of 41 respondents provided data on the total number of IV drug abusers in their State. The highest estimates of IV drug abusers were provided by New York (260,000), California (222,000) and Texas (188,000). The total number of IV drug abusers estimated by all 41 respondents was 1,482,347.

- In response to a request for the top three policy issues, States identified a need for new or expanded treatment services; a need for prevention and treatment services to special populations, such as persons with AIDS and HIV disease, indigent, homeless, dually diagnosed, women and criminal justice clients); a need for administration and staffing; a need for funding and resource allocation; and, a need for prevention and treatment services for youth.

- Narrative responses received from 52 State and Territorial Agencies confirmed that there were major needs in the areas of prevention and treatment for which adequate resources were not available. States identified many needs to meet the requirements of special populations, such as youth, women, dually diagnosed clients, persons with HIV disease and AIDS, minorities,

the homeless and the elderly. Other needs include additional staffing and training, prevention and early intervention services, and special State needs such as site renovation, remodeling and location, as well as a need for assistance in data collection.

- Significant changes in services that occurred during FY 1989 and were reported by the States related primarily to required new services for AIDS and IV drug user populations; client and drug use trends; changes in availability of financial resources for services; and changes in youth prevention and treatment services.

EXECUTIVE SUMMARY

In September of 1987, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), with support from the National Institute on Drug Abuse (NIDA), entered into a second three-year contractual relationship with the National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD) to ensure the continued availability and analysis of data from the States. The contract provides support for the continued analysis of data voluntarily submitted by the States from existing sources of information on alcohol and other drug abuse funding and services. This cooperative Federal-State effort responds to Congressional mandates and ensures that the Institutes and the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) have the information necessary to exercise a strong national leadership role in cooperation with States with regard to alcohol and other drug abuse program needs and services.

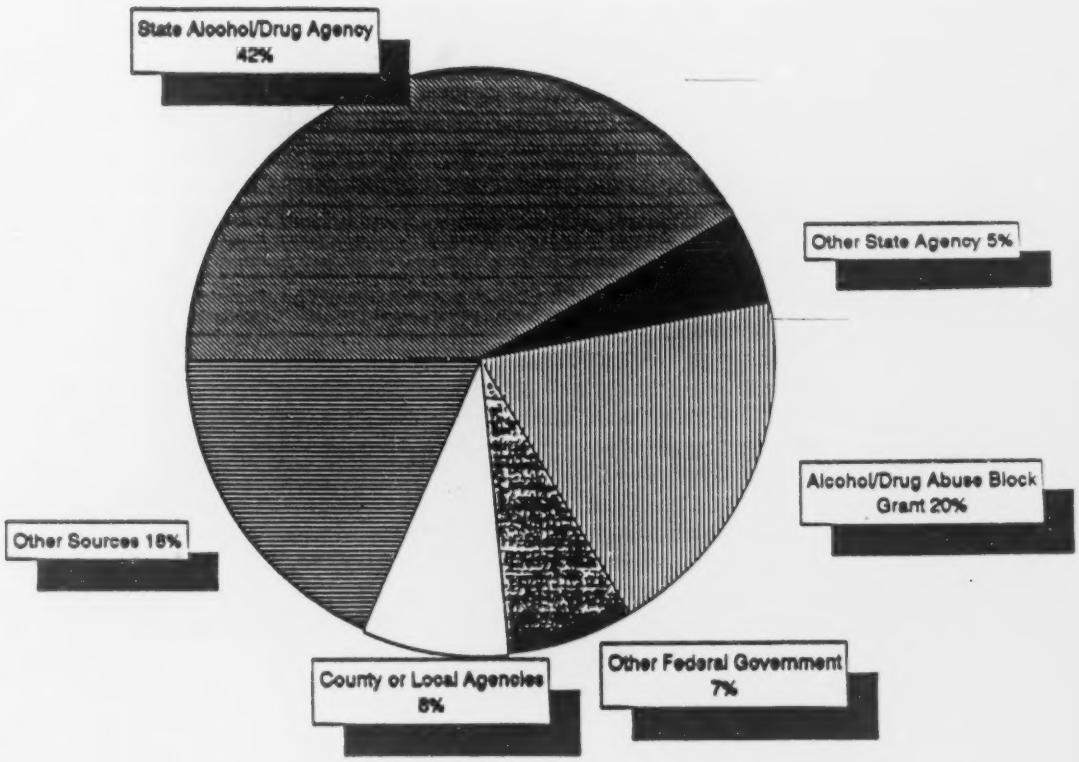
Under the State Alcohol and Drug Abuse Profile (SADAP) contract relevant data from the States and Territories are collected and analyzed. With the cooperation of both Federal and State officials, the SADAP data collection format and process have been continually refined and improved over the past six years.

This report presents and analyzes the results of the State Alcohol and Drug Abuse Profile (SADAP) data for the States' 1989 Fiscal Year (FY). Forty-nine States, the District of Columbia, Guam and Puerto Rico cooperated and contributed information on resources, services and needs related to alcohol and other drug abuse problems within the States and Territories. The remaining information is categorized into the following eight areas: funding levels and sources; client admission characteristics; intravenous (IV) drug abuse; State model product availability; top policy issues; major unmet needs; significant changes in treatment and/or prevention services; and responses to special questions.

Funding Levels and Sources

The total reported expenditures within 49 States, the District of Columbia, Guam and Puerto Rico for alcohol and other drug services in those programs receiving at least some State-administered funds during the State's 1989 Fiscal Year (FY) were over $2.4 billion. As illustrated in Figure 1, this total includes more than $1 billion (41.8 percent) from State Alcohol and Drug Agency sources, $128.6 million (5.3 percent) from other State agency sources, $474.7 million (19.7 percent) from the Alcohol and Drug Abuse Block Grant, $169.9 million (7.0 percent) from other Federal government sources, $191.8 million (7.9 percent) from

FIGURE 1
EXPENDITURES FOR STATE SUPPORTED ALCOHOL AND DRUG ABUSE SERVICES BY FUNDING SOURCE FOR FISCAL YEAR 1989


State Alcohol/Drug Agency 42%
Other State Agency 5%
Alcohol/Drug Abuse Block Grant 20%
Other Federal Government 7%
County or Local Agencies 8%
Other Sources 18%

Total alcohol and drug expenditures for FY 1989 were $2,414,171,837.

NOTE: The Other Sources category includes funding from sources such as client fees, court fines and reimbursements from private health insurance.

SOURCE: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs that received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year 1989."

county or local agency sources, and $440.1 million (18.2 percent) from other sources (e.g., reimbursements from private health insurance, client fees, court fines or assessments for treatment imposed on intoxicated drivers).

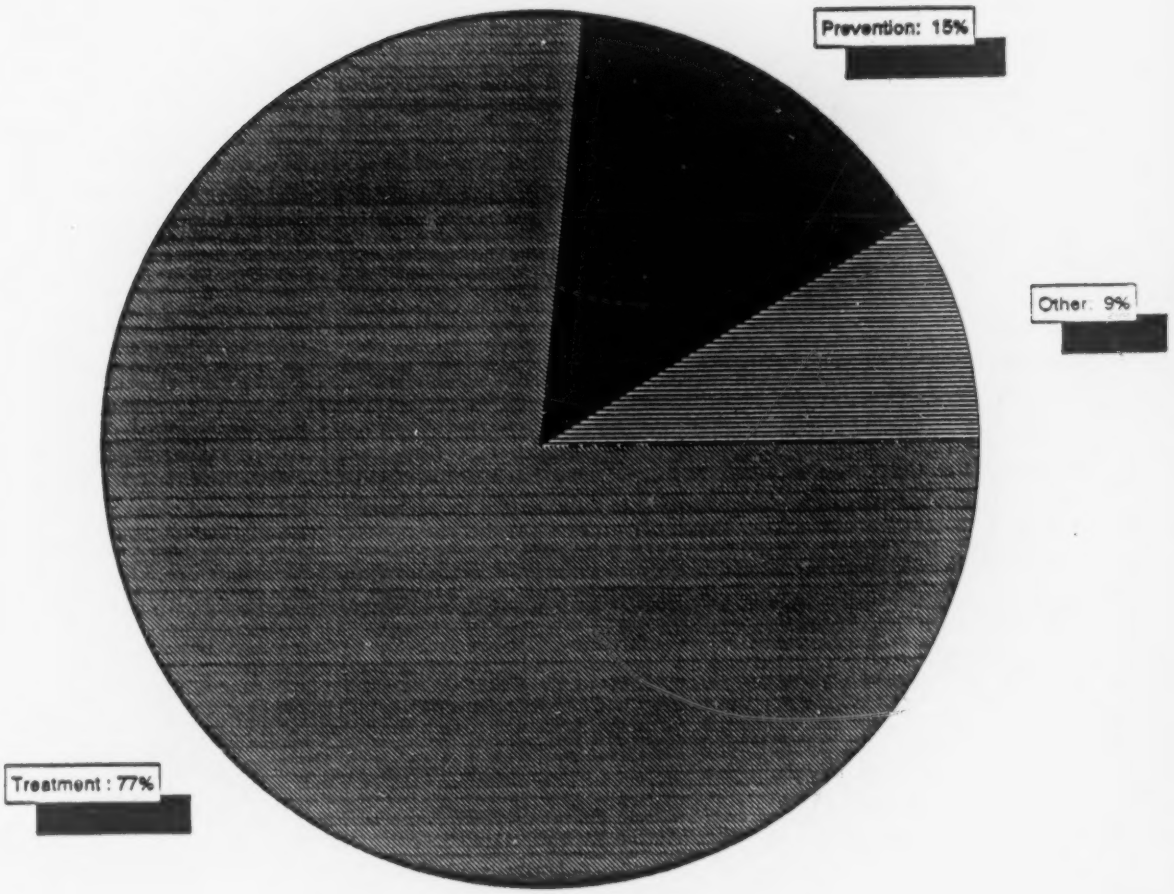
It should be emphasized that the data provided do not include information on those programs that did not receive any funding from the State Alcohol and Drug Agencies in FY 1989. These programs would include most, if not all, private for-profit programs; some private not-for-profit programs, some county and local government programs; and most Federal government programs such as the Veterans Administration. Therefore, the overall fiscal data contained in this report are conservative in nature, and, to some degree, underestimate funding expenditures by other departments of State and Federal Government and by private, non-State Agency-supported alcohol and drug abuse treatment and prevention programs.

Although the specific levels of fiscal support contributed by different sources vary considerably among the States, the single largest source of funding during FY 1989 for alcohol and other drug services was State monies. In 36 States and Territories, State Alcohol and Drug Agency monies constituted the largest source of funding, while in two States and in the District of Columbia, other State revenues were the largest source of support. The Alcohol and Drug Abuse Block Grants from the Federal Government were the largest revenue source in nine States. Among the remaining States other Federal Government monies constituted the largest source of funds in one State and in one Territory and other sources (e.g., private health insurance) constituted the largest revenue source in two States.

Approximately 76.9 percent of the funds were expended for treatment services, 14.6 percent for prevention services, and 8.6 percent for other activities (e.g., training, research, administration) (See Figure 2).

Comparisons of financial expenditures reported by the States in this year's SADAP with data collected for FYs 1985, 1986, 1987 and 1988 are provided (See Figure 3). Although some other revenue sources have experienced larger percentage increases due to their smaller base, the bar graph data shown in Figure 3 clearly demonstrate that State Alcohol and Drug Agency funds have been and continue to be the largest revenue source for alcohol and other drug abuse prevention and treatment services. Comparisons with data collected in earlier FYs (before 1985) are not appropriate. Such comparisons would be misleading since there were changes instituted in the specific wording of questions related to States' fiscal resources (e.g., a change from "allocations" to "expenditures").

FIGURE 2
EXPENDITURES FOR STATE SUPPORTED ALCOHOL AND DRUG ABUSE SERVICES BY TYPE OF PROGRAM ACTIVITY FOR FISCAL YEAR 1989

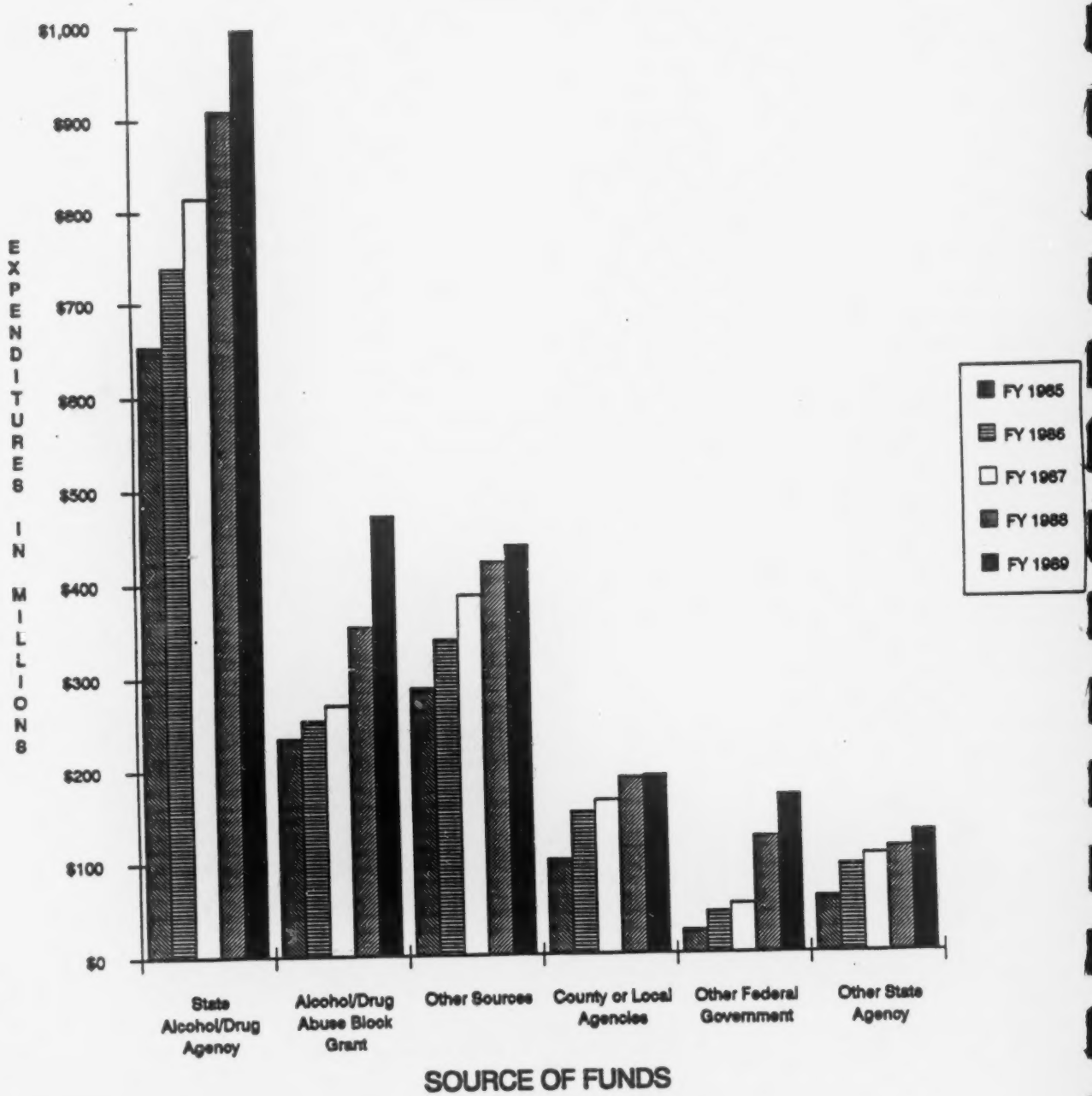


Total alcohol and drug expenditures for FY 1989 were $2,414,171,837.

NOTE: The "Other" category includes expenditures for program activities such as administration, research and training.

SOURCE: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs that received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year 1989."

FIGURE 3
COMPARISON OF EXPENDITURES FOR STATE SUPPORTED ALCOHOL AND DRUG ABUSE SERVICES BY FUNDING SOURCE FOR FISCAL YEARS 1985, 1986, 1987, 1988, AND 1989



NOTE: Some of the apparent increases in expenditures may be related to an improvement in the State's ability to collect and provide data from different funding sources.

NOTE: The "Other" category includes expenditures for program activities such as administration, research and training.

SOURCE: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs that received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year 1989."

The State Agencies identified a total of 7,150 alcohol and/or drug treatment units to which they provided at least some funding in FY 1989. In terms of treatment orientation, 4,461 of the units (62.4 percent) provided combined alcohol/drug treatment services, while 1,449 (20.3 percent) focused on alcoholism services and 1,240 (17.3 percent) concentrated on drug dependency services.

Client Admission Characteristics

The total alcohol and other drug client treatment admissions reported by 48 States, the District of Columbia, Guam and Puerto Rico exceeded 1.8 million (1,838,833), including 1,012,696 (55.1%) client admissions to ambulatory units (924,845 outpatient; 75,502 methadone; and 12,349 detoxification). Admissions to ambulatory units for treatment of alcoholism were 49.3 percent of the total alcohol treatment admissions; drug treatment admissions to ambulatory units comprised 69.0 percent of the total other drug treatment admissions. In the 48 States, the District of Columbia, Guam and Puerto Rico which reported admissions data by sex, 77.5 percent of the alcohol client admissions were male. Other alcohol client admissions characteristics in terms of age were as follows: 4.2 percent under age 18; 4.8 percent 18-20; 10.1 percent 21-24; 32.0 percent 25-34; 22.7 percent 35-44; 10.8 percent 45-54; 5.8 percent 55-64; 1.6 percent age 65 and over; and 7.9 percent not reported. In terms of race/ethnicity, alcohol client admissions were as follows: 69.7 percent White, not of Hispanic origin; 17.2 percent Black, not of Hispanic origin; 6.4 percent Hispanic; .2 percent Asian or Pacific Islander; 3.8 percent Native American (American Indian or Alaskan Native); .7 percent Other; and 2.1 percent not reported.

The total other drug client treatment admissions reported by 48 State Agencies, the District of Columbia, Guam and Puerto Rico were 605,914. Of the 51 State and Territorial Agencies that reported admissions data by sex, 65.7 percent of the drug client admissions were male. Other drug client admissions characteristics in terms of age were as follows: 12.6 percent under age 18; 7.8 percent 18-20; 13.3 percent 21-24; 38.5 percent 25-34; 16.2 percent 35-44; 3.2 percent 45-54; .8 percent 55-64; .3 percent age 65 and over; and 7.3 percent not reported.

In terms of race/ethnicity, drug client admissions, as reported by 48 States, the District of Columbia, Guam and Puerto Rico, were as follows: 52.6 percent White, not of Hispanic origin; 28.4 percent Black,, not of Hispanic origin; 10.2 percent Hispanic; .5 percent Asian or Pacific Islander; 1.1 percent Native American; .3 percent Other; and 6.9 percent not reported.

With regard to primary drug of abuse at admission to treatment the findings for the lead drugs were as follows: cocaine, 210,869 admissions; heroin, 124,727 admissions; marijuana/hashish, 100,450

admissions; amphetamines, 22,659 admissions; other opiates/synthetics (beyond heroin and non treatment use of methadone), 12,747; and PCP 9,241. There exists tremendous variability in drug use and client treatment admission patterns across States and over time. However, one finding that deserves mention is the continuing growth in drug client treatment admissions related to cocaine. From FY 1985 to FY 1989, treatment admissions related to cocaine for those States reporting in both years increased dramatically, from 38,903 in FY 1985 to 208,515 in FY 1989. In FY 1988, cocaine first surpassed heroin as the leading primary drug of abuse. However, by FY 1989, cocaine admissions (208,515) were 67.9 percent higher than heroin admissions (124,186) even though heroin admissions continued to rise over FY 1988.

Intravenous (IV) Drug Abuse

States were asked for the fourth year in a row to provide estimates relating to intravenous (IV) drug abuse for FY 1989 for the total number of client admissions to treatment and for the total number of IV drug abusers in the State. There were 50 State Agency responses on the total number of drug treatment admissions to State funded programs, which ranged from a high of 35,297 in California to a low of 2 in Guam and 26 in North Dakota and totalled 186,805.

Forty-one States and Territories provided data on the total number of IV drug abusers in their State. The highest estimates of IV drug abusers were provided by New York (260,000), California (222,000) and Texas (188,000). The total number of IV drug abusers across the country as estimated by respondents from 38 States, the District of Columbia, Guam and Puerto Rico is 1,482,347.

State Model Product Availability

In order to identify current model product availability within each State, the Agencies were asked to list products that would be of interest to other States and/or that could possibly either be replicated or used in other States. A total of 43 State Agencies responded and reported major product categories which include: treatment plans; prevention plans; counselor certification/ licensure and training standards; program certification/licensure/ accreditation standards; program monitoring systems; and needs assessment survey methodologies.

Top Policy Issues

Forty-nine States, the District of Columbia, Guam and Puerto Rico identified policy questions and issues currently being considered at the State level. The most frequently mentioned policy issues fell into the following categories: need for new or

expanded treatment services; services to special populations including persons at high risk of HIV; administration and staffing; funding and resource allocation; and prevention and treatment services for youth.

Major Unmet Needs

Fifty-two State and Territorial Agencies, indicated that major needs in prevention and treatment were identified through their most recent State planning process for which resources were not adequate to meet those needs. Most States submitted narrative responses describing these unmet needs. In addition to the need for a general increase in funds to support treatment and prevention services, the States indicated other specific needs including increased services to youth and women, as well as for a variety of special population groups including dually diagnosed clients, persons with AIDS and HIV disease, ethnic minorities, the homeless and the elderly. In addition, many States identified the following needs: to increase program staff positions; to expand prevention and early intervention services; and provide training and raise salaries. Special State needs include site renvoation, remodeling and siting, as well as assistance in data collection.

Significant Changes in Treatment and/or Prevention Services

The State Alcohol and Drug Agencies were also asked to provide a narrative description of any significant changes in services that occurred during FY 1989 and the reasons for such changes. A total of 50 narrative responses were received. The scope of the narrative comments related to: required new programs and services for AIDS and IV drug user populations; client and drug use trends (e.g., increases in cocaine and heroin admissions); changes in financial resources; changes in services directed to youth; prevention programs and services; changes in treatment admissions; and other significant developments.

Responses to Special Questions

The State Alcohol and Drug Abuse Agencies were also requested to provide responses to questions in several areas, including issues and concerns relating to measurement of access to appropriate care; prevention and treatment program needs; problems in accessing care for alcohol and drug dependent pregnant women; and information on children born to alcohol and other drug dependent women.

I. INTRODUCTION

Alcohol and other drug abuse and dependency constitute major public health problems in every State and community throughout America. During 1983, the most recent year for which accurate cost estimates are available, the economic costs of these problems totaled over $176 billion (1). These enormous problems must be addressed at all levels of government. At a Federal level, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), the Office for Substance Abuse Prevention (OSAP), and the Office for Treatment Improvement (OTI) have been given lead responsibility to provide national leadership on alcohol and other drug prevention, treatment and research issues. A significant portion of this responsibility focuses on the task of monitoring various indicators of alcohol and other drug abuse, including information on treatment and prevention services and funding resources.

At a State level, the State and Territorial Alcohol and Drug Agencies have administrative responsibility for the allocation and effective utilization of Federal and State monies specifically targeted for alcohol and other drug treatment and prevention services. In order to effectively and efficiently carry out these tasks, each State Agency collects relevant information on needs, services and resources. This information assists the States in their ongoing planning, monitoring and service delivery functions.

Prior to 1982, NIAAA and NIDA were the repositories of detailed information from States and programs on alcohol and other drug treatment and prevention services and clients that were directly supported by Federal monies. Data were reported to the Federal level by the States and/or individual programs as a condition of receipt of the Federal alcohol and drug formula grant and project grant funds. However, when the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant was authorized by Public Law 97-35 in 1981, the requirement for the provision of detailed data from the States and individual programs was no longer mandated.

Nevertheless, the continued importance and need for some national data on alcohol and other drug treatment and prevention programs, services and clients was recognized at both the Federal and State levels. The Senate Committee on Labor and Human Resources included language in its report on the Alcohol and Drug Abuse Amendments of 1983 that referred to data collection as "an important national leadership responsibility of the Institutes". The Committee specifically encouraged the Institutes to acquire

(1) Harwood, H.J., Napolitano, D.M., Kristiansen, P., and Colins, J.J.: Economic Cost to Society of Alcohol, Drug Abuse and Mental Illness: 1983. Research Triangle Institute.

"alcoholism and drug program data from information systems in each State". The Congress eventually directed the Secretary of the Department of Health and Human Services, through the Administrator of ADAMHA to:

> "conduct data collection activities with respect to such programs, including data collection activities concerning the types of alcoholism, alcohol abuse, drug abuse and mental health treatment and prevention activities conducted under such part, the number and types of individuals receiving services under such programs and activities, and the sources of funding (other than funding provided under such part) for such programs and activities" (Section 1920) (42 U.S.C. 300 x).

Part B, Title XIX of the Public Health Services Act further requires that:

> "The Secretary, in consultation with appropriate national organizations, shall develop model criteria and forms for the collection of data and information with respect to services provided under this part in order to enable States to share uniform data and information with respect to the provision of such services."

In order to meet the Congressional mandates for continuing data collection activities and to be able to respond knowledgeably to questions regarding the availability of prevention, intervention and treatment resources to deal with alcohol and other drug abuse, the Federal government has sought to maintain minimal data which are accurate and updated on a regular basis.

Since 1982, the National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD) has demonstrated its capability to effectively and efficiently gather, analyze and present uniform information on alcohol and other drug abuse treatment and prevention resources and clients. Necessary data have been provided by the States and these activities have been supported by NIAAA, NIDA and the States. The States' willingness to provide NASADAD with information on alcohol and drug treatment and prevention services, resources and clients is evidenced by the successful outcome of previous contract efforts which included State data from Fiscal Years (FYs) 1983, 1984, 1985 1986, 1987 and 1988.

On September 30, 1987, NIAAA and NIDA again entered into a contractual relationship with NASADAD to continue support of a cooperative Federal/State national data strategy (Contract No. ADM 281-87-0007). As a key part of this contract, NASADAD is working with ADAMHA, the Institutes and the States to assess, define and

voluntarily provide information on alcohol and other drug abuse services, programs, resources, and needs. The data being collected and analyzed by NASADAD are already in existence at the State level. The major tasks being performed by NASADAD are the definition and collection of information in a uniform format from its members, the analysis of the data submitted by each State, the development of meaningful comparisons of data across States and over time, the provision of a comprehensive report on the findings, and the conduct of two special studies per year.

Under the current contract, data on alcohol and other drug abuse services, programs, resources and needs for Fiscal Years 1987 and 1988 were collected, analyzed and presented in a comprehensive report. The current report analyzes data from FY 1989 and provides comparisons with data from previous fiscal years.

II. STUDY PURPOSE AND METHODOLOGY

The overall purpose of this study and report is to ensure the continued availability of selected service and resource information from already existing State sources throughout the United States and the Territories. The specific data elements include, but are not limited to, financial, program, and client data that States are willing to voluntarily submit to assist NIAAA and NIDA in assessing the types of treatment and prevention resources and services provided to persons throughout the country who are dependent upon or abusing alcohol and/or other drugs.

The major study objectives are:

- To provide continued support for the implementation of a joint Federal/State national data strategy, through collaboration on the State Alcohol and Drug Abuse Profile (SADAP) and the National Drug and Alcohol Treatment Unit Survey (NDATUS). State representatives are involved by providing consultation in examining options and developing recommendations for appropriate refinements and changes in the scope and content of existing and future efforts to acquire data from the States.

- To annually compile secondary data from the States relating to alcohol and other drug abuse services, clients and resources.

- To automate the editing, storage and analysis of data acquired from the States in prior and current fiscal years.

- To aggregate and analyze the data that are voluntarily submitted by each State, including the development of comparisons and analyses within and across States.

The overall study methodology was defined within a performance plan comprised of four major tasks and related sub-tasks, including the design of data acquisition and analysis plans; development of support materials and procedures; implementation of data acquisition and analysis; and the preparation of numerous project reports.

Subsequent to a meeting in September of 1989 with State and Institute representatives to solicit input and recommendations for the 1989 SADAP form, NASADAD staff developed all necessary support materials. Data collection procedures were implemented in October of 1989 when those support materials were distributed to the State Alcohol and Drug Agency Directors along with a data request letter signed by NASADAD's President. Attached as Appendix A is a copy of the cover letter, information collection format, and glossary of

terms that were sent to each State Alcohol and Drug Abuse Agency Director. This material was followed by written communications to States reminding them of the importance of voluntarily submitting the data. Telephone calls were then made to any Directors who had not submitted information within the requested time frame.

The Directors of the State Alcohol and Drug Agencies from 49 States, the District of Columbia, Guam and Puerto Rico voluntarily submitted information in response to the request from NASADAD. The data received are summarized and analyzed within the remaining sections of this report. Each State Director was provided a draft copy of the data tables and requested to review and verify the accuracy of all information from his/her State.

III. FUNDING OF ALCOHOL AND OTHER DRUG SERVICES

In October of 1989, a letter was sent to each State Alcohol and Drug (A/D) Agency with a request to provide data on total expenditures for alcohol and other drug services by source of funding and type of program activity within the State for that State's Fiscal Year (FY) 1989. Forty-nine States, the District of Columbia, Guam, and Puerto Rico responded to this request.

Before presenting and analyzing the findings, it is important to note that, as with any data, these data have a number of inherent limitations. They should not be utilized without an appreciation of the qualifications that apply to them. One major qualification is that the States were asked to report total expenditures for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989." The data presented do not include information on those programs that did not receive any funding from the State A/D Agency (e.g., most, if not all, private for-profit programs; some private not-for-profit programs; and some public programs). As a result, the overall fiscal estimates contained herein are conservative in nature and, to varying degrees, underestimate funding expenditures by other departments of State government, by Federal agencies such as the Veterans Administration, and by private, non-State Agency supported alcohol and drug abuse treatment and prevention programs.

The financial and related data collected from States for FY 1989 are organized within five major subsections:

- Financial Expenditures by State and Funding Source;
- Financial Expenditures by Type of Program Activity;
- Comparison of Financial Expenditures for Fiscal Years 1985, 1986, 1987, 1988 and 1989 by Total Expenditures, Funding Source and Type of Program Activity;
- Total Number and Percent of Treatment Units That Received Funds Administered by the State Alcohol/Drug Agency in Fiscal Year 1989; and
- Information on Medicaid Reimbursement.

Information on each of these areas follows:

1. Financial Expenditures by State and Funding Source (Table 1)

This subsection provides information on expenditures for alcohol and drug services within each State during that State's

1989 Fiscal Year. It should be noted that two States, Alabama and Michigan, and the District of Columbia have Fiscal Years directly comparable to the Federal Government (October 1 to September 30), while 46 States and Puerto Rico have Fiscal Years from July 1 to June 30, one State (New York) has a Fiscal Year from April 1 to March 31, and one State (Texas) has a Fiscal Year from September 1 to August 31. The data are categorized and presented on both a State-by-State basis and by funding source, including State Alcohol and Drug Agency funds, other State monies, the alcohol and drug portion of the Alcohol, Drug Abuse and Mental Health Services (ADMS) and the Emergency Alcohol and Drug Treatment and Rehabilitation (ADTR) Block Grants, other Federal monies, County and local funds, and monies from other sources. Also, total expenditures are reported for forty-nine States, the District of Columbia, Guam and Puerto Rico for each funding source (see Table 1).

The total monies expended within all forty-nine States, the District of Columbia, Guam and Puerto Rico for alcohol and drug services in those programs receiving at least some State-administered funds during each State's 1989 Fiscal Year (FY) were $2,414,171,837. This total includes more than $1 billion (41.8 percent) from State A/D Agency sources, $128.6 million (5.3 percent) from other State agency sources, $474.7 million (19.7 percent) from the ADMS and ADTR Block Grants, $169.9 million (7.0 percent) from other Federal government sources, $191.8 million (7.9 percent) from county or local agency sources, and $440.1 million (18.2 percent) from other sources (e.g., reimbursements from private health insurance, client fees, court fines or assessments for treatment imposed on intoxicated drivers).

Caution needs to be exercised in utilizing and interpreting these data. As noted earlier, the data include information for "only on those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year 1989." In some States complete information is not available on all funding sources, even for State Alcohol/Drug (A/D) Agency-supported programs. In most instances where such information is not presented, the amount of such funding, if any, is probably minimal. However, since in some instances such funding may be substantial, the percents presented in Table 1 should be used only as gross estimates of the overall level of funding from various sources. It is likely that the "Other State," "Other Federal," "County or Local" and particularly, the "Other Sources" categories actually contribute more funds and higher percents than the figures indicate.

The specific levels of fiscal support contributed by the different sources vary considerably among the States. It is clear, however, that for all States combined and for most States

TABLE 1

EXPENDITURES FOR STATE-SUPPORTED ALCOHOL AND OTHER DRUG ABUSE SERVICES
BY STATE AND BY FUNDING SOURCE FOR FISCAL YEAR 1989

STATE	STATE ALCOHOL/ DRUG AGENCY	OTHER STATE AGENCY	ALCOHOL/ DRUG ABUSE BLOCK GRANT	OTHER FEDERAL GOVERNMENT	COUNTY OR LOCAL AGENCIES	OTHER SOURCES	GRAND TOTAL	
Alabama	2,565,194	N/A	6,434,653	48,916	N/A	2,592	9,051,355	
Alaska	14,843,300	869,900	2,542,300	5,014,500	3,182,400	1,907,000	28,359,400	
Arizona	11,373,259	N/A	6,904,090	0	N/A	9,322,810	27,600,159	A
Arkansas	1,694,802	1,397,927	3,928,804	974,321	583,334	0	8,579,188	
California	80,896,000	1,257,000	91,738,000	35,631,000	37,899,091	84,868,692	332,289,783	
Colorado	11,626,746	1,006,902	7,612,029	1,166,905	4,601,705	5,185,559	31,199,846	
Connecticut	39,650,694	0	7,339,332	3,100,147	0	17,918,525	68,008,698	
Delaware	3,084,606	17,389	1,469,756	136,000	N/A	8,086	4,715,837	
District of Col.	130,825	27,219,188	2,815,850	1,957,501	0	1,544,539	33,667,903	
Florida	42,822,607	318,180	21,816,736	790,490	21,916,004	0	87,664,017	
Georgia	28,713,600	0	9,600,765	1,526,017	861,038	3,792,519	44,493,939	
Guam	N/A	N/A	31,830	50,400	N/A	N/A	82,230	
Hawaii	2,371,061	185,556	1,258,880	105,674	27,000	1,020,191	4,968,362	
Idaho	1,756,016	3,500	1,550,793	283,773	0	0	3,594,082	
Illinois	55,078,572	436,832	18,360,282	2,856,388	N/A	N/A	76,732,074	
Indiana	3,290,085	11,637,469	6,126,039	4,696,747	1,815,082	3,179,374	30,744,796	
Iowa	8,381,395	1,670,654	3,984,816	393,592	2,153,642	3,470,548	20,054,647	
Kansas	5,269,003	431,460	3,399,516	372,000	1,831,112	3,499,261	14,802,352	
Kentucky	5,306,551	2,669,159	4,893,895	736,718	1,429,304	0	15,035,627	
Louisiana	4,583,191	0	6,457,593	0	0	495,319	11,536,103	
Maine	6,293,644	1,385,517	2,409,862	N/A	N/A	N/A	10,089,023	
Maryland	34,332,900	0	7,023,700	749,500	4,632,000	10,730,000	57,468,100	
Massachusetts	45,174,839	0	13,470,640	960,528	0	0	59,606,007	
Michigan	28,980,537	0	21,824,793	3,164,136	10,007,302	19,887,668	83,864,436	
Minnesota	28,279,200	0	10,484,455	2,500,000	10,215,700	0	51,479,355	
Mississippi	2,326,624	615,352	3,426,500	2,414,486	N/A	N/A	8,782,962	
Missouri	10,577,694	N/A	8,508,262	1,174,207	N/A	N/A	20,260,163	
Montana	521,872	2,132,699	1,455,727	1,173,613	1,233,016	7,415,102	13,932,029	
Nebraska	4,633,268	0	2,877,579	78,504	579,225	861,464	9,030,040	
Nevada	2,336,689	0	2,674,915	303,545	59,937	2,874,169	8,249,255	B
New Hampshire	2,566,048	0	1,679,478	20,335	0	167,878	4,433,739	
New Jersey	29,925,000	1,154,000	12,037,000	7,219,000	2,801,000	6,442,000	59,578,000	
New Mexico	12,439,853	0	1,819,289	927,686	0	0	15,186,828	
New York	242,359,672	10,830,143	53,429,794	11,634,079	37,615,433	184,649,111	540,518,232	ACDE
North Carolina	27,388,261	0	4,336,710	5,829,885	0	0	37,554,856	
North Dakota	728,749	N/A	2,335,672	199,756	0	N/A	3,264,177	
Ohio	16,411,196	702,775	10,205,388	1,751,225	1,732,240	15,598,983	46,401,807	
Oklahoma	12,061,123	0	4,626,006	861,465	N/A	N/A	17,548,594	
Oregon	7,200,426	34,360,080	6,048,322	28,086,849	5,131,311	0	80,826,988	
Pennsylvania	31,830,434	8,578,612	19,365,770	956,791	8,816,672	19,898,249	89,446,528	
Puerto Rico	17,431,833	655,266	6,996,017	2,293,904	N/A	3,284,000	30,661,020	F
Rhode Island	11,501,052	0	1,860,240	719,388	0	0	14,080,680	GH
South Carolina	8,964,889	4,715,222	4,071,568	2,252,350	4,360,378	7,750,112	32,114,519	
South Dakota	461,113	417,220	1,276,876	230,741	674,684	1,251,148	4,311,782	
Tennessee	8,641,320	1,486,767	5,731,092	1,609,649	6,343,705	3,032,814	26,845,347	
Texas	4,516,055	0	22,047,859	3,852,523	0	0	30,416,437	
Utah	5,790,060	614,190	3,529,137	223,231	2,837,805	3,063,762	16,058,185	
Vermont	2,785,063	440,000	1,310,334	184,796	N/A	N/A	4,720,193	I
Virginia	19,374,877	N/A	8,203,821	N/A	11,811,086	6,163,147	45,552,931	
Washington	39,130,000	0	7,920,000	1,270,000	0	0	48,320,000	
West Virginia	2,780,685	312,963	3,474,741	0	147,555	921,785	7,637,729	
Wisconsin	17,916,600	11,084,377	9,949,600	27,375,600	6,500,820	9,924,500	82,751,497	
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
TOTALS	1,009,099,083	128,606,299	474,677,106	169,858,861	191,799,581	440,130,907	2,414,171,837	
PERCENT OF TOTAL	41.8%	5.3%	19.7%	7.0%	7.9%	18.2%	100.0%	

A = Figures represent allocated funds rather than expenditures.
B = County or Local Agencies category includes required matching funds.
C = Other State Agency category includes methadone registry, capital construction, and Medicaid MIS suballocation from Dept. of Social Services.
D = Other Federal Government category includes the Federal Crime Control and Safe Street Act, Western New York Prevention Project through the Division of Criminal Justice Services, Community Youth Activity Grant, Developmental Disabilities Planning Council Grant, Drug Use Forecasting Program Grant, States Helping States Grant, Uniform Alcohol and Drug Abuse Data Collection System Grant, and Intensive Supervision Project Grant fund by Div. of Criminal Justice Services from an NIJ grant. Also includes $10,000,000 Federal waiting list reduction grant money.
E = Other Sources category includes Medicaid, client fees, etc.
F = Other Sources category includes donations to private programs which offer prevention and treatment services.
G = Figures represent an estimate of expenditures.
H = State Alcohol/Drug Agency category includes appropriation and statistical accounts.
I = Other State category includes alcohol and drug funds which are generated from fees charged by the State A/D Agency and which are part of the appropriation of the State A/D Agency.

N/A = Information not available.

Cautionary Note: In a number of States complete information is not available on all funding sources for State supported programs. In most instances where such information is not presented the amount of such funding, if any, is probably minimal. However, since in some instances such funding may be substantial, the percents presented at the bottom of this table should be used only as gross estimates of the overall levels of funding from various sources. It is likely that the "Other State," "Other Federal," "County or Local" and "Other Sources" categories actually contribute more monies and higher percents than the figures shown.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989

individually, the single largest source of funding during FY 1989 for alcohol and drug services was State revenues. In 35 States and Puerto Rico the State A/D Agency funds constituted the single largest source of funding. The largest revenue source in nine States, was the Federal government, primarily through the alcohol and drug abuse share of the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant, but also partially through the Part C, Emergency Alcohol and Drug Treatment and Rehabilitation (ADTR) Block Grant. In two States and the District of Columbia, other State agency monies were the major source of support; in another two States, other sources constituted the largest funding source; and within Wisconsin and Guam other Federal government monies was the major source of support.

2. Financial Expenditures by State and Type of Program Activity (Table 2)

Within this subsection information is provided on the amount of monies expended during FY 1989 for different types of alcohol and drug program activities. Data are presented on a State-by-State basis for three program activities including treatment, prevention, and other. Total expenditures are reported for each State and for each program activity category (see Table 2).

As noted previously, the total monies expended within the forty-nine States, the District of Columbia, Guam and Puerto Rico during FY 1989 in those programs that received at least some State A/D Agency funds were over $2.4 billion. All of these States and Territories were able to report the breakout of the funds into the different types of alcohol and other drug program activities. Of the total, approximately $1.9 billion (76.9 percent) was expended for treatment activities, $351.4 million (14.6 percent) for prevention activities, and $207.2 million (8.6 percent) for other activities (e.g., training, research, and administration).

Over the past several years, many States have substantially increased their commitment to and financial expenditures for prevention programs. However, within every State Agency the expenditures for treatment remain much higher than those for prevention. Overall, the expenditures for treatment are over five times as great as for prevention.

3. Comparison of Financial Expenditures for Fiscal Years 1985, 1986, 1987, 1988 and 1989 by State, Type of Program Activity, Total Expenditures and Funding Source (Tables 3, 4, 5)

Detailed comparisons of financial expenditures reported by States in this year's State Alcohol and Drug Abuse Profile (SADAP) with SADAP data collected for FYs 1985, 1986, 1987 and 1988 are provided in this subsection. However, comparisons with fiscal data

TABLE 2

EXPENDITURES FOR STATE-SUPPORTED ALCOHOL AND OTHER DRUG ABUSE SERVICES
BY STATE AND BY TYPE OF PROGRAM ACTIVITY FOR FISCAL YEAR 1989

STATE	TYPE OF PROGRAM ACTIVITY			
	TREATMENT	PREVENTION	OTHER	TOTAL
Alabama	7,897,635	850,820	302,900	9,051,355
Alaska	21,442,400	4,502,700	2,414,300	28,359,400
Arizona	25,451,346	1,660,711	488,102	27,600,159 A
Arkansas	7,409,820	676,779	492,589	8,579,188
California	227,670,642	64,325,228	40,293,913	332,289,783
Colorado	23,866,811	5,587,384	1,745,651	31,199,846
Connecticut	56,609,363	4,277,942	7,121,393	68,008,698
Delaware	3,929,745	541,583	244,509	4,715,837
District of Col	28,220,306	3,011,117	2,436,480	33,667,903
Florida	79,724,238	7,716,747	223,032	87,664,017
Georgia	40,586,002	1,407,609	2,500,328	44,493,939
Guam	49,338	16,446	16,446	82,230
Hawaii	3,945,258	713,173	309,931	4,968,362
Idaho	2,906,064	427,201	260,817	3,594,082
Illinois	60,452,156	8,651,408	7,628,510	76,732,074
Indiana	27,162,216	2,619,173	963,407	30,744,796
Iowa	15,680,325	3,724,978	649,344	20,054,647
Kansas	11,948,723	1,756,154	1,097,475	14,802,352
Kentucky	11,536,974	2,576,342	922,311	15,035,627
Louisiana	9,508,694	1,223,245	804,164	11,536,103
Maine	7,090,939	2,050,051	948,033	10,089,023
Maryland	49,349,000	4,909,200	3,209,900	57,468,100
Massachusetts	50,351,136	4,863,076	4,391,795	59,606,007
Michigan	59,807,172	15,199,787	8,857,477	83,864,436
Minnesota	45,912,600	459,840	5,106,915	51,479,355
Mississippi	6,607,990	685,300	1,489,672	8,782,962
Missouri	17,388,780	1,486,323	1,385,060	20,260,163
Montana	12,252,545	1,239,473	440,011	13,932,029
Nebraska	7,690,631	956,051	383,358	9,030,040
Nevada	6,846,247	754,299	648,709	8,249,255
New Hampshire	2,989,183	669,789	774,767	4,433,739
New Jersey	43,312,000	9,523,000	6,743,000	59,578,000
New Mexico	13,665,704	1,257,503	263,621	15,186,828
New York	405,872,041	81,565,468	53,080,723	540,518,232 A
North Carolina	33,624,204	2,426,924	1,503,728	37,554,856
North Dakota	2,731,072	444,784	88,321	3,264,177
Ohio	35,362,510	6,665,698	4,373,599	46,401,807
Oklahoma	15,601,009	1,299,682	647,903	17,548,594
Oregon	47,045,861	29,058,989	4,722,138	80,826,988
Pennsylvania	65,443,971	15,372,433	8,630,124	89,446,528
Puerto Rico	19,022,581	4,649,426	6,989,013	30,661,020
Rhode Island	10,896,494	2,802,134	382,052	14,080,680
South Carolina	20,322,085	9,492,388	2,300,046	32,114,519
South Dakota	3,789,630	356,224	165,928	4,311,782
Tennessee	18,002,396	5,530,614	3,312,337	26,845,347
Texas	18,902,286	7,628,759	3,885,392	30,416,437
Utah	12,181,561	3,158,888	717,736	16,058,185
Vermont	3,214,729	827,015	678,449	4,720,193
Virginia	40,977,984	4,574,947	0	45,552,931
Washington	45,750,000	850,000	1,720,000	48,320,000
West Virginia	6,112,110	900,420	625,199	7,637,729
Wisconsin	61,399,338	13,498,414	7,853,745	82,751,497
Wyoming	N/A	N/A	N/A	N/A
TOTALS	1,855,513,845	351,423,639	207,234,353	2,414,171,837
PERCENT OF TOTAL	76.9%	14.6%	8.6%	100.0%

A = Figures represent allocated funds rather than expenditures.

N/A = Information not available.

Note: "OTHER" category includes other activities beyond treatment or prevention services, e.g., training, research and administration.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/ Drug Agency during the State's Fiscal Year (FY) 1989."

collected in FYs 1982-1984 are not appropriate. Such comparisons would be misleading since there were changes instituted in the specific wording of questions related to States' fiscal resources.

In fiscal years 1982, 1983 and 1984, States were asked to "estimate" their current year's fiscal allocation while they were still in the middle of the fiscal year. Thus, the States could only provide "estimates" of dollar allocations for all alcohol and drug services within their States. In 1984, two major refinements were made to the data collection effort: States were asked to report actual allocations for their most recently completed fiscal year (FY 1984) and to provide fiscal information for "only those programs which received at least some funds administered by the State alcohol/drug agency during Fiscal Year 1984." In 1985, a third refinement was added: States were asked to report actual total "expenditures" for FY 1985 rather than "allocations."

A comparison of total expenditures for all funding sources for alcohol and drug abuse services from FY 1985 to FY 1989 in the 50 jurisdictions reporting data for all five years, reflects a total dollar increase from FY 1985 to FY 1989 of $1,037,125,644 or a 76.2 percent increase (see Table 3). While this reflects a positive growth in the overall national fiscal environment, one State Agency with severe fiscal problems reported a decrease in total expenditures from FY 1985 to FY 1989. And 10 others experienced only modest increases (an average that is less than 5% per year) over the four year period. Also, in a few States, the increase in expenditures may reflect not a true increase in monies for services but instead may reflect an improvement in the reporting or data collection system. In addition, it may be worth noting that the dollar increase from FY 1985 to FY 1986 was 19.1 percent, while the increase from FY 1986 to FY 1987 was only 10.5 percent, the increase from FY 1987 to FY 1988 was 17.8 percent, and the increase from FY 1988 to 1989 was 13.6 percent - the latest increase was significant but still below the prior increase from FY 1987 to FY 1988.

A comparison of expenditures by funding source from FY 1985 to FY 1989 is also provided (see Table 4). All categories of funding sources reveal significant increases in expenditures from FY 1985 to FY 1989. Caution needs to be exercised when comparing these financial data, however, as some of the apparent increases may be related in part to an improvement in the State's ability to collect and provide data. A comparison of these expenditure data from FY 1985 to FY 1989 document the following increases: "State Alcohol/ Drug Agency" (52.3 percent); "Other State Agency" (118.3 percent); "Alcohol/Drug Abuse Block Grants" (101.2 percent); "Other Federal Government" (594.6 percent); "County or Local Agencies" (89.9

TABLE 3

EXPENDITURES FOR STATE-SUPPORTED ALCOHOL AND OTHER DRUG ABUSE SERVICES
BY STATE FOR FISCAL YEARS 1985, 1986, 1987, 1988, AND 1989

STATE	TOTAL ALCOHOL AND DRUG ABUSE SERVICE EXPENDITURES					1985 to 1989 CHANGE
	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	
Alabama	5,915,793	6,628,533	7,303,100	9,999,051	9,051,355	53.0%
Alaska	19,511,863	18,866,700	21,528,100	25,198,047	28,359,400	45.3%
Arizona	20,218,120	21,273,146	22,377,637	23,881,542	27,600,159	36.5%
Arkansas	5,403,542	5,770,019	6,654,927	8,029,382	8,579,188	58.8%
California	201,933,720	211,861,000	221,072,000	261,474,670	332,289,783	64.6%
Colorado	16,219,222	24,498,392	25,446,218	27,518,339	31,199,846	92.4%
Connecticut	27,087,735	36,290,844	40,466,215	57,951,823	68,008,698	151.1%
Delaware	3,756,902	3,496,879	4,006,730	4,521,439	4,715,837	25.5%
District of Col	18,897,677	23,756,425	26,579,185	30,771,287	33,667,903	78.2%
Florida	42,891,735	62,217,740	74,781,721	75,132,664	87,664,017	104.4%
Georgia	23,797,742	29,029,176	32,145,874	39,319,963	44,493,939	87.0%
Hawaii	3,673,124	4,533,022	4,349,258	5,109,783	4,968,362	35.3%
Idaho	2,822,875	2,878,325	2,405,900	3,548,345	3,594,082	27.3%
Illinois	47,356,816	61,155,276	65,509,900	68,056,900	76,732,074	62.0%
Indiana	17,683,691	21,893,125	21,310,966	22,105,345	30,744,796	73.9%
Iowa	12,281,053	14,938,060	14,637,903	17,684,279	20,054,647	63.3%
Kansas	8,402,000	9,951,855	11,868,600	14,118,882	14,802,352	76.2%
Kentucky	7,900,941	9,497,100	10,371,525	14,321,677	15,035,627	90.3%
Louisiana	12,814,939	14,840,614	11,339,400	12,233,154	11,536,103	-10.0%
Maine	8,632,814	6,398,023	7,310,944	9,317,983	10,089,023	16.9%
Maryland	28,149,997	40,803,832	42,365,613	47,539,942	57,468,100	104.1%
Massachusetts	35,934,301	34,588,516	48,910,423	50,520,000	59,606,007	65.9%
Michigan	65,545,875	77,031,584	80,857,857	81,401,541	83,864,436	27.9%
Minnesota	5,009,800	5,327,587	5,378,812	46,052,625	51,479,355	927.6%
Mississippi	6,826,300	6,094,081	5,527,359	6,433,410	8,782,962	28.7%
Missouri	11,402,338	13,389,238	16,375,024	16,947,288	20,260,163	77.7%
Montana	8,060,073	9,175,393	9,863,356	12,386,601	13,932,029	72.9%
Nebraska	6,183,667	6,836,388	7,618,509	8,656,129	9,030,040	46.0%
Nevada	6,552,090	5,548,531	5,999,831	7,594,946	8,249,255	25.9%
New Hampshire	2,335,190	2,251,114	2,406,233	3,067,060	4,433,739	89.9%
New Jersey	22,307,000	44,058,000	38,658,000	45,311,570	59,578,000	167.1%
New York	309,368,481	370,369,815	450,522,342	504,208,790	540,518,232	74.7%
North Carolina	29,179,859	28,753,576	34,850,619	40,165,453	37,554,856	28.7%
North Dakota	1,777,000	2,827,269	2,795,597	2,538,860	3,264,177	83.7%
Ohio	35,960,797	68,441,833	36,761,949	63,772,225	46,401,807	29.0%
Oklahoma	5,923,068	10,984,639	11,581,816	9,510,058	17,548,594	196.3%
Oregon	10,915,230	11,324,766	40,171,578	60,600,918	80,826,988	640.5%
Pennsylvania	65,712,000	69,570,000	74,213,581	86,250,353	89,446,528	36.1%
Puerto Rico	17,503,724	17,956,398	21,423,297	24,499,713	30,661,020	75.2%
Rhode Island	7,292,084	7,496,722	9,332,346	11,295,332	14,080,680	93.1%
South Carolina	12,512,296	20,356,999	24,075,988	29,468,452	32,114,519	156.7%
South Dakota	4,015,716	3,479,520	3,976,883	4,114,909	4,311,782	7.4%
Tennessee	10,100,800	14,194,276	19,852,378	21,044,649	26,845,347	165.8%
Texas	20,433,115	14,389,108	14,527,476	24,784,644	30,416,437	48.9%
Utah	12,929,062	15,377,966	17,117,638	16,485,593	16,058,185	24.2%
Vermont	3,778,941	4,957,943	5,441,463	4,419,773	4,720,193	24.9%
Virginia	27,027,873	29,490,704	31,539,019	36,699,439	45,552,931	68.5%
Washington	21,666,028	22,288,236	24,711,601	36,563,998	48,320,000	123.0%
West Virginia	7,447,581	6,851,015	7,800,503	8,509,016	7,637,729	2.6%
Wisconsin	52,724,554	67,863,733	65,971,112	70,765,312	82,751,497	57.0%
TOTALS	1,361,777,135	1,621,853,036	1,792,094,306	2,111,903,154	2,398,902,779	76.2%

N/A = Information not available.

Note: The FY 1989 totals for this table differ from Tables 1 and 2 because data in this Table are only depicted for those State and Territorial Agencies that reported all four years (ie., data for Guam, New Mexico, Virgin Islands, and Wyoming are thus not included). In addition, for a number of States the increases in expenditures shown include not only actual increases in monies, but also improved and more complete reporting of expenditure information over time.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/ Drug Agency during the State's Fiscal Year (FY) 1989."

TABLE 4

COMPARISON OF EXPENDITURES FOR ALCOHOL AND OTHER DRUG ABUSE SERVICES
BY FUNDING SOURCE FOR FISCAL YEARS 1985, 1986, 1987, 1988, AND 1989

FUNDING SOURCE	FY 1985	1985-1986 CHANGE	FY 1986	1986-1987 CHANGE	FY 1987	1987-1988 CHANGE	FY 1988	1988-1989 CHANGE	FY 1989	1985 TO 1989 CHANGE
STATE ALCOHOL/ DRUG AGENCY	654,430,812	12.8%	738,498,313	10.3%	814,604,015	11.7%	909,875,851	9.5%	996,659,230	52.3%
OTHER STATE AGENCY	58,916,203	57.8%	92,950,375	11.5%	103,603,708	7.4%	111,294,111	15.6%	128,606,299	118.3%
ALCOHOL/DRUG ABUSE BLOCK GRANT	235,051,006	8.1%	254,130,628	6.3%	270,186,698	31.2%	354,597,948	33.3%	472,825,987	101.2%
OTHER FEDERAL GOVERNMENT	24,313,096	80.7%	43,932,752	17.8%	51,766,318	139.2%	123,848,528	36.4%	168,880,775	594.6%
COUNTY OR LOCAL AGENCIES	100,983,237	51.1%	152,578,725	7.8%	164,547,873	15.2%	189,586,170	1.2%	191,799,581	89.9%
OTHER SOURCES	288,082,781	17.9%	339,762,243	14.0%	387,385,694	9.1%	422,700,546	4.1%	440,130,907	52.8%
GRAND TOTAL	1,361,777,135	19.1%	1,621,853,036	10.5%	1,792,094,306	17.8%	2,111,903,154	13.6%	2,398,902,779	76.2%

TABLE 5

COMPARISON OF EXPENDITURES FOR ALCOHOL AND OTHER DRUG ABUSE SERVICES
BY TYPE OF PROGRAM ACTIVITY FOR FISCAL YEARS 1985, 1986, 1987, 1988, AND 1989

TYPE OF ACTIVITY	FY 1985	1985-1986 CHANGE	FY 1986	1986-1987 CHANGE	FY 1987	1987-1988 CHANGE	FY 1988	1988-1989 CHANGE	FY 1989	1985 TO 1989 CHANGE
TREATMENT	1,017,605,931	16.6%	1,186,940,131	13.2%	1,344,060,626	21.6%	1,634,935,457	12.7%	1,841,798,803	81.0%
PREVENTION	154,254,660	20.6%	186,016,989	19.6%	222,471,046	39.3%	309,859,328	13.0%	350,149,690	127.0%
OTHER **	189,916,544	31.1%	248,895,916	-9.4%	225,562,634	-25.9%	167,108,369	23.8%	206,954,286	9.0%
GRAND TOTAL	1,361,777,135	19.1%	1,621,853,036	10.5%	1,792,094,306	17.8%	2,111,903,154	13.6%	2,398,902,779	76.2%

** "OTHER" Type of Activity category includes activities beyond treatment or prevention services, e.g., training, research and administration.

Note: The FY 1989 totals for these tables differ from Tables 1 and 2 because data in this table are only depicted for those State and Territorial Agencies that reported all four years (ie., data from Guam, New Mexico, Virgin Islands, and Wyoming are thus not included). In addition, for a number of States the increases in expenditures shown include not only actual increases in monies, but also improved and more complete reporting of expenditure information over time.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/ Drug Agency during the State's Fiscal Year (FY) 1989."

percent) and "Other Sources" (52.8 percent), for an overall total increase from FY 1985 to FY 1989 of 76.2 percent. Figure 3, included earlier within the Executive Summary of this document, presents these data in a bar graph format.

Overall expenditures by types of Program Activity for the State Agencies able to report such data for FY 1985 through FY 1989 (see Table 5) reflect a significant growth in expenditures for treatment and prevention. Total expenditures for treatment increased by $824,192,872 (81.0 percent) from FY 1985 to FY 1989 and total expenditures for prevention activities increased by $195,895,030 (127.0 percent) over these five years. Expenditures, for other activities increased by $17,037,742 (9.0 percent) after showing a decrease in FY 1988.

4. Total Number and Percent of Treatment Units that Received Funds Administered by the State Alcohol/Drug Agency in Fiscal Year 1989 (Tables 6 and 7)

Within this subsection information is provided on the total number of treatment units that received funds administered by the State A/D Agency in FY 1989. The data are presented by primary orientation of the treatment units: alcohol, drug, or combined alcohol/drug. An estimate is also provided indicating the percent of treatment units in the State in FY 1989 that received any funds administered by the State A/D Agency.

The State Agencies identified a total of 7,150 alcohol and/or drug treatment units that received funds administered by the State A/D Agency in FY 1989. With regard to the orientation of the treatment units, 1,449 (20.3 percent) were identified as alcohol units, 1,240 (17.3 percent) as drug units and 4,461 (62.4 percent) were identified as combined alcohol/drug treatment units (see Table 6).

An estimate of the percent of total alcohol and/or drug treatment units in the State that received any funds administered by the State A/D Agency in FY 1989 was provided by 48 States, the District of Columbia, Guam and Puerto Rico. The estimate ranged from a State low of 23 percent in Indiana, to a territorial high of 100 percent in Guam and a State high of 98 percent in Vermont (see Table 7).

Included as Appendix B of this report are State-by-State population, per capita income, population density and State revenue figures to aid in further analyses and interpretation of the financial data. Population data are for July 1, 1989; the population density data are for July 1, 1988; the per capita income data are for Calendar Year 1988 and the overall State revenues reflect each State's Fiscal Year 1989.

TABLE 6

NUMBER OF ALCOHOL AND/OR DRUG TREATMENT UNITS WHICH RECEIVED FUNDS ADMINISTERED BY THE STATE ALCOHOL/DRUG AGENCY FOR FISCAL YEAR 1989

STATE	ALCOHOL TREATMENT UNITS	DRUG TREATMENT UNITS	COMBINED ALCOHOL/ DRUG TREATMENT UNITS	TOTAL ALCOHOL/ DRUG TREATMENT UNITS
Alabama	0	0	47	47
Alaska	0	2	39	41
Arizona	17	12	115	144
Arkansas	2	5	40	47
California	635	322	N/A	957
Colorado	51	4	44	99
Connecticut	26	63	37	126
Delaware	4	2	10	16
District of Col	4	7	15	26
Florida	N/A	N/A	90	90
Georgia	0	0	41	41
Guam	0	0	1	1
Hawaii	0	1	19	20
Idaho	0	0	45	45
Illinois	0	0	295	295 A
Indiana	0	0	65	65
Iowa	0	0	31	31
Kansas	2	1	48	51
Kentucky	0	1	132	133
Louisiana	0	0	54	54
Maine	0	0	39	39
Maryland	0	14	125	139
Massachusetts	0	0	248	248
Michigan	1	0	259	260
Minnesota	0	10	233	243
Mississippi	7	1	53	61
Missouri	5	4	66	75
Montana	1	3	26	30
Nebraska	0	0	121	121
Nevada	9	1	19	29
New Hampshire	0	0	34	34
New Jersey	140	70	20	230
New Mexico	21	8	18	47
New York (A)	362	0	8	370 B
New York (D)	0	477	N/A	477
North Carolina	0	0	154	154
North Dakota	0	0	8	8
Ohio	63	111	84	258
Oklahoma	0	1	60	61
Oregon	32	4	90	126
Pennsylvania	14	11	298	323
Puerto Rico	12	65	77	154
Rhode Island	8	4	28	40
South Carolina	2	0	38	40
South Dakota	0	0	28	28
Tennessee	0	0	55	55
Texas	0	0	74	74
Utah	11	0	54	65
Vermont	0	0	26	26
Virginia	10	17	212	239 C
Washington	10	17	97	124
West Virginia	0	0	60	60
Wisconsin	0	2	581	583
Wyoming	N/A	N/A	N/A	N/A
TOTALS	1,449	1,240	4,461	7,150
PERCENT OF TOTAL	20.3%	17.3%	62.4%	100.0%

A = Combined alcohol/drug treatment units represent non-hospital sites.
B = Combined alcohol/drug treatment units represent residential facilities for chemically dependent youths.
C = Source of information: FY 1989 CSB Data Survey Report 1989.

N/A = Information not available.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency" during the State's Fiscal Year (FY) 1989".

TABLE 7

ESTIMATE OF PERCENT OF TOTAL ALCOHOL AND/OR DRUG TREATMENT UNITS IN EACH STATE THAT RECEIVED ANY FUNDS ADMINISTERED BY THE STATE ALCOHOL/DRUG AGENCY FOR FISCAL YEAR 1989

STATE	ESTIMATE OF PERCENT OF TOTAL TREATMENT UNITS FUNDED BY STATE AGENCY
Alabama	65
Alaska	68
Arizona	70
Arkansas	77
California	60
Colorado	32
Connecticut	53
Delaware	50
District of Col	33
Florida	49
Georgia	N/A
Guam	100
Hawaii	75
Idaho	65
Illinois	77
Indiana	23
Iowa	54
Kansas	29
Kentucky	52
Louisiana	33
Maine	58
Maryland	53
Massachusetts	85
Michigan	38
Minnesota	95
Mississippi	75
Missouri	46
Montana	75
Nebraska	83
Nevada	33
New Hampshire	31
New Jersey	50
New Mexico	85
New York (A)	66
New York (D)	77
North Carolina	70
North Dakota	30
Ohio	70
Oklahoma	58
Oregon	85
Pennsylvania	53
Puerto Rico	50
Rhode Island	96
South Carolina	60
South Dakota	90
Tennessee	60
Texas	26
Utah	58
Vermont	98
Virginia	90
Washington	34
West Virginia	93
Wisconsin	95
Wyoming	N/A

N/A = Information not available.

A = Alcohol Agency in New York State.
D = Drug Agency in New York State.

Source: State Alcohol and Drug Abuse Profile, FY 1989.

5. Information on Medicaid Reimbursement

For the first time as part of the Fiscal Year 1989 SADAP, State Agency respondents were asked to provide information on the status of Medicaid reimbursement for alcohol and other drug services within their State. Specifically, the States were given three options with regard to Medicaid. They were asked to check: (1) whether Medicaid currently does reimburse the cost of some alcohol and/or other drug treatment services; (2) whether Medicaid currently does not reimburse for alcohol and/or other drug services, but the State Agency is currently seeking such reimbursement; or (3) whether Medicaid currently does not reimburse for alcohol and/or other drug services, and the State is seeking such reimbursement.

Representatives from a total of 39 State and Territorial Agencies indicated that within their State Medicaid reimburses the cost of some alcohol and/or other drug treatment services (see Table 8). These State and Territorial Agencies included the following: Alabama, Arizona, Arkansas, California, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, West Virginia and Wisconsin. Ten States do not currently have such Medicaid reimbursement for alcohol and/or other drug treatment services but are in the process of exploring its implementation, while two States plus Guam and Puerto Rico do not currently have Medicaid reimbursement nor are they currently attempting to seek such reimbursement.

TABLE 8

STATUS OF MEDICAID REIMBURSEMENT FOR ALCOHOL AND OTHER DRUG SERVICES
BY STATE FOR FISCAL YEAR 1989

STATE	Medicaid Does Reimburse	Medicaid Does Not Reimburse - Seeking	Medicaid Does Not Reimburse - Not Seeking	
Alabama	X			
Alaska		X		
Arizona	X			A
Arkansas	X			B
California	X			
Colorado		X		
Connecticut	X			
Delaware		X		C
District of Col	X			
Florida	X			
Georgia	X			
Guam			X	
Hawaii	X			D
Idaho		X		
Illinois	X			
Indiana		X		
Iowa	X			
Kansas	X			E
Kentucky		X		
Louisiana	X			
Maine	X			
Maryland	X			
Massachusetts	X			
Michigan	X			
Minnesota	X			
Mississippi	X			
Missouri	X			
Montana	X			F
Nebraska		X		
Nevada			X	
New Hampshire		X		
New Jersey	X			G
New Mexico	X	X		H
New York	X (A&D)			
North Carolina	X			
North Dakota	X			
Ohio	X			
Oklahoma	X			
Oregon	X			
Pennsylvania	X			
Puerto Rico			X	
Rhode Island	X			
South Carolina	X			
South Dakota			X	
Tennessee	X			
Texas	X			
Utah	X			
Vermont	X			
Virginia		X		
Washington	X			
West Virginia	X			
Wisconsin	X			
Wyoming	N/A			

N/A = Information not available.

A = The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's federally approved alternative to Medicaid.
B = Juveniles in medical based settings.
C = New funds available for methadone prescriptions only.
D = Only for medical time and supplies for methadone clinics.
E = Currently paying only in hospital's MHC's. Now exploring funding in community residential programs.
F = Reimbursement for Detoxification Services only in a licensed hospital.
G = Limited drug treatment reimbursement only; alcoholism reimbursement not available.
H = Reimburses up to five days for detox in an acute care facility.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989".

IV. CLIENT ADMISSIONS TO ALCOHOL AND OTHER DRUG TREATMENT SERVICES

Each State Alcohol and Drug Agency was asked to provide information on client admissions to treatment units that received funds administered by the State Agency during Fiscal Year 1989. All but one State (New York) have combined alcohol and other drug abuse treatment responsibilities within one State Agency. A number of these agencies have established combined (e.g., alcohol and other drug, substance abuse, chemical dependency) treatment systems and/or client reporting systems and preferred to report combined alcohol and other drug client data. In previous years NASADAD, in response to a specific request from NIAAA and NIDA, collected separate data related to alcohol and other drug abuse treatment services. However, with the concurrence of the Institute Project Officers, for FY 1989 States were asked for the first time to provide combined alcohol and other drug information when submitting data on treatment admissions by environment and by type of care. Consistent with past data collection efforts, other client admissions information (i.e., sex, age, race/ethnicity, primary drug of abuse) continues to be reported as separate alcohol and other drug client data.

In reviewing and interpreting the data in this section of the report, it is important to recognize that the client admissions figures are limited to those treatment units that "received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989". Also, States reporting client information on those treatment units that received only partial funding from the State Agency were instructed to report data on all client admissions to the program, not just data on those client admissions supported by State Agency funds. The data presented do not include client admissions to treatment units that did not receive any funds administered by the State Alcohol or Drug Agency during FY 1989. In addition, it is important to recognize that the number of admissions shown in the Not Reported category may not always be equal across tables, since different States may not be able to provide client admissions for all of the categories specified (e.g., some States use different age categories).

The remainder of this section on client admissions to treatment services is organized within five major subsections including:

- Alcohol and Other Drug Client Admissions Data by Environment and Type of Care;
- Alcohol Client Admissions Data by Sex, Age, Race/Ethnicity and Dual Addiction Problems;
- Drug Client Admissions Data by Sex, Age, Race/Ethnicity and Dual Addiction Problems;

- o Drug Client Admissions Data by Primary Drug of Abuse; and
- o Comparisons of Client Admissions Data for Fiscal Years 1985, 1986, 1987, 1988 and 1989.

Information on each of these areas is presented within the following paragraphs.

1. Alcohol and Other Drug Client Admissions Data by Environment and Type of Care (Tables 9 and 10)

Forty-eight State Agencies, the District of Columbia, Guam and Puerto Rico provided at least some data on the number of total alcohol and other drug client treatment admissions during FY 1989 (see the last column in Table 9). The total reported treatment admissions during the year was over 1.8 million, including 1,215,731 alcohol treatment admissions, 599,634 other drug treatment admissions, and 23,468 treatment admissions where the type of admission (i.e., alcohol or other drug) was Not Reported.

Prior to the 1989 SADAP data collection effort States had been requested to provide separate alcohol and other drug information related to client admissions by environment and by type of care. The information previously requested included client admissions data organized by environment (hospital or non-hospital for alcohol; and hospital, residential or outpatient for drug) and by type of care (detoxification, rehabilitation/residential, or outpatient for alcohol; and detoxification, maintenance, or drug free for drug). However, as a follow-up to ongoing recommendations from the States, for FY 1989 NASADAD asked the States to combine the separate environment and modality information into one consistent set of categories which are as follows: (1) Detoxification, 24 Hour/Day Care - hospital inpatient, or free-standing residential; (2) Rehabilitation/Residential - hospital (other than detoxification), short-term (30 days or less), or long-term (over 30 days); and (3) Ambulatory - outpatient, methadone, or detoxification (non-methadone). Also, each of these categories was subdivided by alcohol treatment admissions and/or drug treatment admissions (see Table 10). Of the total client admissions by treatment environment and modility 55 percent (1,012,696 admissions) were ambulatory including (924,845 outpatient, 75,502 methadone, and 12,349 detoxification - see Table 10, page 2. In addition, total admissions included 27 percent (493,424) for detoxification, 24 hour/day care and 17 percent (313,715) for rehabilitation/ residential care.

Alcohol treatment admissions to ambulatory care (559,037 admissions) comprised 49 percent of the total alcohol treatment admissions (1,215,731), while drug treatment

TABLE 9

NUMBER OF ALCOHOL AND OTHER DRUG CLIENT TREATMENT ADMISSIONS
BY STATE FOR FISCAL YEAR 1989

STATE	ALCOHOL	OTHER DRUG	NOT REPORTED	TOTAL	
Alabama	7,308	5,381	0	12,689	
Alaska	8,960	1,863	0	10,823	
Arizona	18,458	7,525	0	25,983	
Arkansas	7,512	3,600	0	11,112	
California	109,562	63,978	0	173,540	
Colorado	54,446	4,602	0	59,048	
Connecticut	17,311	8,449	0	25,760	
Delaware	3,386	1,877	0	5,263	
District of Col	5,627	6,237	0	11,864	
Florida	57,446	25,393	0	82,839	
Georgia	31,306	24,043	0	55,349	
Guam	71	7	0	78	
Hawaii	2,282	2,026	0	4,308	
Idaho	4,722	2,225	0	6,947	
Illinois	48,508	32,171	0	80,679	
Indiana	11,936	6,848	0	18,784	
Iowa	18,511	4,636	0	23,147	
Kansas	10,294	3,982	0	14,276	
Kentucky	N/A	N/A	22,355	22,355	
Louisiana	5,909	7,309	0	13,218	
Maine	13,962	4,995	0	18,957	
Maryland	18,172	17,834	0	36,006	
Massachusetts	61,675	34,789	0	96,464	A
Michigan	35,409	24,644	0	60,053	
Minnesota	53,065	10,800	0	63,865	
Mississippi	7,614	3,780	0	11,394	
Missouri	25,578	9,379	0	34,957	
Montana	8,230	2,149	0	10,379	
Nebraska	22,942	2,561	0	25,503	
Nevada	8,451	2,148	0	10,599	
New Hampshire	5,057	1,131	0	6,188	
New Jersey	29,658	13,656	0	43,314	
New Mexico	13,311	3,526	(757)	16,080	B
New York	161,306	85,904	0	247,210	CD
North Carolina	25,776	5,019	0	30,795	
North Dakota	1,975	650	0	2,625	
Ohio	17,002	21,285	0	38,287	
Oklahoma	8,902	4,273	1,870	15,045	E
Oregon	30,874	9,055	0	39,929	
Pennsylvania	33,202	32,508	0	65,710	
Puerto Rico	6,664	9,184	0	15,848	
Rhode Island	10,074	4,597	0	14,671	
South Carolina	27,026	7,982	0	35,008	
South Dakota	4,222	3,750	0	7,972	
Tennessee	8,303	7,522	0	15,825	
Texas	15,925	15,093	0	31,018	
Utah	12,612	3,084	0	15,696	
Vermont	3,232	2,290	0	5,522	
Virginia	36,014	19,395	0	55,409	
Washington	N/A	N/A	N/A	N/A	
West Virginia	11,789	1,719	0	13,508	
Wisconsin	74,154	22,780	0	96,934	
Wyoming	N/A	N/A	N/A	N/A	
TOTALS	1,215,731	599,634	23,468	1,838,833	
PERCENT OF TOTAL	66.1%	32.6%	1.3%	100.0%	

A = Total does not include 2,850 collateral admissions.
B = The 757 clients listed as in New Mexico's Not Reported category represent those clients admitted to more than one service category.
C = Other drug total does not include 2,751 admissions to non-funded methadone programs.
D = For the alcohol client information, responses used actual calendar year 1988 data.
E = "Not Reported" includes 67 short-term rehabilitation/residential and 610 ambulatory/outpatient clients. 1093 clients were treated in "other service categories". These clients cannot be identified by alcohol or other drug.

N/A = Information not available.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

NUMBER OF ALCOHOL AND OTHER DRUG CLIENT TREATMENT ADMISSIONS BY TYPE OF ENVIRONMENT, TYPE OF CARE, AND STATE FOR FISCAL YEAR 1989

	DETOXIFICATION, 24 HOUR/DAY CARE						REHABILITATION/RESIDENTIAL								
	HOSPITAL INPATIENT			FREE-STANDING RESIDENTIAL			HOSPITAL (OTHER THAN DETOX)			SHORT-TERM (30 DAYS OR LESS)			LONG-TERM (OVER 30 DAYS)		
STATE	ALCOHOL	OTHER DRUG	TOTAL	ALCOHOL	OTHER DRUG	TOTAL	ALCOHOL	OTHER DRUG	TOTAL	ALCOHOL	OTHER DRUG	TOTAL	ALCOHOL	OTHER DRUG	TOTAL
Alabama	N/A	N/A	N/A	305	436	741	N/A	N/A	N/A	944	966	1,910	712	410	1,122
Alaska	169	29	169	1,471	319	1,790	0	0	0	1,477	320	1,797	316	69	385
Arizona	0	11	20	2,600	280	2,880	0	0	0	1,440	259	1,699	1,313	803	2,116
Arkansas	0	0	0	1,130	346	1,476	0	0	0	0	0	0	3,332	1,486	4,818
California	0	0	0	46,830	1,845	48,375	0	0	0	23,394	7,642	30,836	0	0	0 1A
Colorado	0	0	0	37,923	0	37,923	0	0	0	1,739	79	1,..18	1,413	311	1,724
Connecticut	3,977	1,383	5,200	5,283	144	5,427	790	0	790	1,901	141	1,642	1,218	772	1,990
Delaware	0	0	0	3,262	1,135	3,397	0	0	0	434	0	434	12	68	80
District of Col	0	390	390	2,949	886	3,836	0	0	0	846	0	846	233	843	816
Florida	N/A	4,482	4,482	17,234	464	17,698	N/A	0	0	N/A	0	0	20,106	7,598	27,704 1BC
Georgia	6,466	1,866	8,332	7,134	5,396	12,880	0	0	0	0	0	0	1,296	1,894	3,188
Guam	4	0	4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hawaii	0	0	0	798	114	913	0	0	0	43	43	186	289	339	628
Idaho	5	1	6	881	274	1,155	0	0	0	486	233	708	0	0	0 1D
Illinois	N/A	N/A	N/A	19,316	12,000	31,736	N/A	N/A	N/A	6,113	3,106	7,219	1,428	1,966	3,300
Indiana	0	0	0	3,737	1,917	5,654	0	0	0	1,399	1,144	2,843	1,301	1,065	2,366
Iowa	0	0	0	160	76	236	0	0	0	786	127	1,907	346	165	413
Kansas	0	0	0	2,967	1,167	3,294	65	33	98	992	668	1,677	435	294	729
Kentucky	N/A	N/A	N/A	N/A	N/A	3,629	N/A	N/A	N/A	N/A	N/A	3,000	N/A	N/A	240
Louisiana	0	0	0	743	1,266	2,009	0	0	0	785	948	1,733	303	280	583
Maine	0	0	0	1,124	848	1,972	0	0	0	617	196	812	1,967	618	2,575
Maryland	0	0	0	1,094	0	1,094	0	0	0	2,107	273	2,380	1,878	884	1,962
Massachusetts	0	0	0	23,439	8,849	31,988			0	4,207	819	5,826	6,619	5,462	12,081 1E
Michigan	0	0	0	3,336	2,884	6,220	0	0	0	2,629	2,639	4,668	2,297	3,732	6,129
Minnesota	0	0	0	41,489	0	41,489	3,480	3,737	7,217	827	1,976	2,803	1,260	2,423	3,683
Mississippi	0	0	0	0	0	0	91	662	753	3,313	734	4,047	930	156	1,086
Missouri	0	0	0	12,489	1,439	13,928	0	0	0	5,315	3,268	8,583	0	0	0
Montana	1,731	143	1,874	72	6	78	1,852	341	2,193	634	349	973	146	34	180
Nebraska	6	1	7	11,896	236	12,132	20	52	80	843	193	736	848	430	1,278
Nevada	0	0	0	6,889	230	7,097	0	0	0	962	274	836	233	938	1,171
New Hampshire	85	10	95	2,988	233	3,231	0	0	0	315	117	432	146	77	223
New Jersey	7,974	216	7,290	5,834	0	5,834	612	0	612	4,998	0	4,998	462	1,737	2,199
New Mexico			0	2,930	84	3,014			0	2,...	N/A	3,829	300	16	296 1F
New York	30,874	471	39,945	26,747	302	26,949	0	0	0	10,363	0	10,363	2,282	9,819	12,201 1G
North Carolina	0	0	0	9,966	262	9,228	0	0	0	2,296	9	2,296	227	280	707
North Dakota	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ohio	0	0	0	4,262	0	4,262	0	0	0	1,484	1,829	3,283	1,274	0	1,274
Oklahoma	0	0	0	987	454	1,361	0	0	0	1,986	290	2,276	29	0	29 1I
Oregon	0	0	0	4,960	1,199	6,959	0	0	0	1,187	443	1,600	1,252	841	1,893
Pennsylvania	4,291	6,753	10,934	4,300	3,769	8,969	384	1,342	1,596	8,270	5,646	10,916	N/A	N/A	N/A
Puerto Rico	713	0	713	0	4,012	4,012	167	0	167	0	1,981	1,981	135	858	693
Rhode Island	2,914	823	3,437	1,893	114	2,007	0	0	0	2,889	1,196	3,084	583	163	748
South Carolina	0	0	0	3,843	1,949	5,492	0	0	0	3,418	736	3,154	379	143	422
South Dakota	0	0	0	684	843	1,196	0	0	0	943	736	1,871	213	201	414
Tennessee	60	32	92	1,843	1,865	3,127	304	145	349	668	738	1,396	647	712	1,379
Texas	941	510	1,451	3,257	3,715	5,972	5,837	0	5,836			0	2,127	4,484	6,611
Utah	30	0	30	5,497	260	5,757	0	0	0	N/A	N/A	N/A	2,263	678	3,041
Vermont	0	0	0	196	234	430	0	0	0	383	433	836	N/A	N/A	N/A
Virginia			0	4,854	3,614	7,468	106	57	163			0	2,814	1,364	3,868
Washington	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
West Virginia	5	12	17	720	98	828	98	83	185	1,639	274	1,913	265	42	307
Wisconsin	3,894	1,196	5,090	0	0	0	0	0	0	13,496	4,146	17,641	5,001	1,659	7,660
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTALS	70,829	17,949	98,778	338,581	82,456	494,646	13,660	6,361	20,039	122,264	43,308	166,732	70,199	54,313	124,984

A = Rehabilitation/Residential Short-term includes short and long term residential clients.

B = Detoxification Freestanding Residential alcohol includes hospital inpatient.

C = Rehabilitation/Residential Long-term alcohol includes short term and hospital (other than detoxification).

D = Total represents duplicate counts; a certain percentage of admissions enter more than one treatment modality.

E = Total does not include 2,830 collateral admissions.

F = The 787 clients listed in New Mexico's Not Reported category represent those clients admitted to more than one service category.

Footnotes continue on following page.

N/A = Information not available.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

NUMBER OF ALCOHOL AND OTHER DRUG CLIENT TREATMENT ADMISSIONS BY TYPE OF ENVIRONMENT, TYPE OF CARE, AND STATE FOR FISCAL YEAR 1989

STATE	OUTPATIENT			AMBULATORY METHADONE			DETOXIFICATION (non-methadone)			NOT REPORTED BY TREATMENT MODALITY			TOTAL		NOT REPORTED	TOTAL	
	ALCOHOL	OTHER DRUG	TOTAL	ALCOHOL	OTHER DRUG	TOTAL	ALCOHOL	OTHER DRUG	TOTAL	ALCOHOL	OTHER DRUG	TOTAL	ALCOHOL	OTHER DRUG			
Alabama	5,318	3,113	8,431	0	474	474	9	2	11	0	0	0	7,308	5,381	0	12,689	
Alaska	8,886	978	4,834	0	148	148	0	0	0	0	0	0	8,948	1,063	0	10,823	
Arizona	13,996	4,000	17,996	0	1,811	1,811	0	341	341	0	0	0	10,458	7,525	0	25,983	
Arkansas	3,800	1,768	4,818	0	0	0	0	0	0	0	0	0	7,512	3,600	0	11,113	
California	39,438	26,552	65,990	0	27,877	27,877	0	662	662	0	0	0	109,562	63,978	0	173,540	1A
Colorado	13,371	3,476	16,847	N/A	736	736	N/A	N/A	0	0	0	0	84,446	4,682	0	89,048	
Connecticut	4,548	4,186	8,726	3	1,903	1,906	0	0	0	0	0	0	17,311	8,449	0	25,760	
Delaware	676	562	1,238	0	113	113	0	0	0	0	0	0	3,306	1,877	0	5,263	
District of Col	1,889	1,894	3,783	0	3,894	3,894	0	0	0	0	0	0	5,627	6,237	0	11,864	
Florida	9,766	11,836	21,896	0	906	906	10,349	113	10,463	0	0	0	57,446	25,393	0	82,839	1BC
Georgia	16,430	14,699	30,829	0	388	388	0	0	0	0	0	0	31,306	24,843	0	56,349	
Guam	67	7	74	N/A	N/A	0	0	0	0	0	0	0	71	7	0	78	
Hawaii	1,132	1,161	2,293	0	369	369	0	0	0	0	0	0	3,282	3,026	0	6,308	
Idaho	3,300	1,728	5,108	0	0	0	0	0	0	0	0	0	4,732	2,235	0	6,967	1D
Illinois	23,892	12,418	36,010	62	3,284	3,346	N/A	N/A	0	0	0	0	48,508	32,171	0	80,679	
Indiana	8,499	3,532	8,031	9	200	200	0	0	0	0	0	0	11,936	6,948	0	18,784	
Iowa	17,300	3,766	21,074	3	96	99	12	6	18	0	0	0	18,311	4,836	0	23,147	
Kansas	6,713	1,813	8,528	N/A	N/A	0	0	0	0	0	0	0	10,294	3,982	0	14,276	
Kentucky	N/A	N/A	0	N/A	N/A	0	N/A	N/A	0	0	0	0	N/A	N/A	22,355	22,355	
Louisiana	4,979	4,815	8,893	0	0	0	0	0	0	0	0	0	5,909	7,309	0	13,218	
Maine	10,364	3,334	13,898	0	0	0	0	0	0	0	0	0	13,962	4,998	0	18,887	
Maryland	12,093	12,426	24,519	0	4,251	4,251	0	0	0	0	0	0	18,172	17,834	0	36,006	
Massachusetts	27,374	16,627	44,001	36	3,332	3,368	0	0	0	0	0	0	61,675	34,789	0	96,464	1E
Michigan	27,048	14,615	41,663	0	1,264	1,264	0	40	40	0	0	0	35,689	24,644	0	60,853	
Minnesota	8,989	3,291	9,280	0	273	273	0	0	0	0	0	0	53,045	10,000	0	63,965	
Mississippi	3,200	2,228	5,800	0	0	0	0	0	0	0	0	0	7,614	3,700	0	11,394	
Missouri	7,776	4,341	12,115	0	391	391	0	0	0	0	0	0	26,378	8,378	0	34,957	
Montana	3,005	1,276	5,081	0	0	0	0	0	0	0	0	0	8,230	2,149	0	10,379	
Nebraska	9,681	1,568	11,169	0	81	81	0	0	0	0	0	0	22,942	2,561	0	25,503	
Nevada	797	498	1,295	0	200	200	0	0	0	0	0	0	6,451	2,148	0	10,599	
New Hampshire	2,803	784	3,587	0	0	0	0	0	0	0	0	0	5,057	1,131	0	6,188	
New Jersey	11,078	5,369	16,443	0	6,318	6,318	0	0	0	0	0	0	29,686	13,686	0	43,314	
New Mexico	7,133	3,930	10,062	0	462	462	40	34	74	0	0	0	13,311	3,836	(787)	16,860	1F
New York	75,320	62,195	137,516	0	14,616	14,616	0	0	0	0	0	0	161,306	85,904	0	247,210	1GI
North Carolina	14,653	3,630	17,683	0	734	734	74	13	87	0	0	0	25,776	5,019	0	30,795	
North Dakota	1,975	650	2,625	0	0	0	0	0	0	0	0	0	1,975	650	0	2,625	
Ohio	10,813	19,456	29,468	0	N/A	0	0	N/A	0	0	0	0	17,982	21,285	0	39,267	
Oklahoma	5,825	3,325	9,150	188	184	389	0	0	0	0	0	0	8,982	4,273	1,870	15,045	1I
Oregon	23,805	6,295	29,710	0	667	667	0	0	0	0	0	0	30,874	9,055	0	39,929	
Pennsylvania	19,874	13,396	32,430	0	1,725	1,725	0	15	15	3	2	5	33,281	32,500	0	65,710	1A
Puerto Rico	5,649	2,990	8,339	0	310	310	0	385	385	0	0	0	6,664	9,191	0	15,048	
Rhode Island	3,825	2,052	4,877	0	540	540	0	0	0	0	0	0	10,974	4,597	0	14,671	
South Carolina	20,784	8,836	25,823	0	116	116	0	0	0	0	0	0	27,926	7,982	0	35,908	
South Dakota	2,810	2,281	4,791	0	0	0	0	0	0	0	0	0	4,223	3,750	0	7,973	
Tennessee	3,933	2,968	6,901	0	49	49	0	0	0	1,229	1,303	2,532	8,303	7,522	0	15,825	
Texas	3,768	7,190	10,868			0	5	275	280	0	0	0	15,925	15,993	0	31,918	
Utah	4,686	1,830	6,436	N/A	300	300	116	7	123	0	0	0	12,612	3,904	0	16,696	
Vermont	2,643	1,623	4,266	0	0	0	0	0	0	0	0	0	3,232	2,290	0	5,522	
Virginia	28,940	15,370	43,910			0			0	0	0	0	36,914	19,395	0	56,409	1HL
Washington	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
West Virginia	9,884	1,293	10,261	0	0	0	0	0	0	0	0	0	11,789	1,719	0	13,508	
Wisconsin	51,385	13,497	64,882	0	278	278	0	3	11	0	0	0	74,184	22,780	0	96,934	
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
TOTALS	588,166	336,679	924,845	356	78,344	78,682	10,613	1,736	12,349	1,232	1,305	2,537	1,215,731	599,634	23,468	1,838,833	

B = Alcohol client information based on actual calendar year 1988 data.

E = Ambulatory Methadone does not include 2,751 admissions to non-funded methadone programs.

I = Total Not Reported includes 67 Short-Term Rehabilitation/Residential clients and 710 Ambulatory/Outpatient clients. 1,093 clients were treated in "other service categories". These clients cannot be identified by alcohol or other drugs.

J = Detoxification Free-Standing Residential Alcohol & Other Drug includes Hospital Inpatient.

K = Rehabilitation/Residential Long Term includes Short Term admissions.

L = Ambulatory Outpatient includes Methadone and Detoxification (Non-Methadone)

N/A = Information not available.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

admissions to ambulatory care (413,659) comprised 69 percent of the total other drug treatment admissions (599,634).

Also, a large proportion of treatment admissions for both alcohol and other drug treatment received care in an outpatient setting. For example, 48 percent of all alcohol client admissions and 56 percent of all drug client admissions were treated in an outpatient setting. Free-standing detoxification services were used by 22 percent of the total alcohol and drug client admissions (i.e., 404,646 of 1,838,833 admissions), while short-term rehabilitation residential facilities treated 9 percent of all alcohol and drug client admissions (i.e., 168,732 of 1,838,833 admissions). Since some of the State Agencies reported more complete data in some categories than in others, caution should be excercised in the interpretation and use of the specific numbers and percentages noted above.

2. Alcohol Client Admissions Data by Sex, Age, Race /Ethnicity and Dual Addiction Problems (Tables 11, 12, 13, 14, and 15)

Each State Alcohol (and combined Alcohol and Drug) Agency was asked to provide data on the "the number of ALCOHOL treatment client admissions during FY 1989" in all units "that received at least some funds administered by the State Alcohol Agency" in each of a number of specific sex, age, and race/ethnicity, and dual addiction categories. Forty-eight States, the District of Columbia, Guam and Puerto Rico reported alcohol client admissions data by sex (see Table 11). Approximately 77.5 percent of the alcohol client admissions were male, and 21.7 percent were female. Data on sex were not reported for .8 percent of the alcohol client admissions.

Forty-five States, the District of Columbia and Guam were able to report data by all or at least most of the age categories requested (see Table 12). The percent of client admissions that fell within each of the age range categories requested were as follows:

Age	Percent of Admissions
Under 18	4.2%
18-20	4.8%
21-24	10.1%
25-34	32.0%
35-44	22.7%
45-54	10.8%
55-64	5.9%
65 and over	1.6%
Not reported	8.0%

TABLE 11

NUMBER OF ALCOHOL CLIENT TREATMENT ADMISSIONS
BY SEX AND STATE FOR FISCAL YEAR 1989

STATE	SEX			TOTAL
	MALE	FEMALE	NOT REPORTED	
Alabama	5,463	1,845	0	7,308
Alaska	6,577	2,383	0	8,960
Arizona	13,646	4,812	0	18,458
Arkansas	6,334	1,178	0	7,512
California	84,910	24,652	0	109,562
Colorado	44,876	9,570	0	54,446
Connecticut	10,488	2,007	4,816	17,311
Delaware	2,817	569	0	3,386
District of Col	4,898	729	0	5,627
Florida	44,670	12,776	0	57,446
Georgia	25,433	5,873	0	31,306
Guam	56	15	0	71
Hawaii	1,691	591	0	2,282
Idaho	3,657	1,065	0	4,722
Illinois	36,864	10,853	791	48,508
Indiana	9,071	2,865	0	11,936
Iowa	14,284	4,227	0	18,511
Kansas	8,466	1,828	0	10,294
Kentucky	10,587	2,680	2,977	16,244
Louisiana	4,540	1,369	0	5,909
Maine	10,445	3,517	0	13,962
Maryland	14,469	3,703	0	18,172
Massachusetts	51,685	9,990	0	61,675
Michigan	27,291	8,118	0	35,409
Minnesota	43,730	8,921	414	53,065
Mississippi	6,407	1,207	0	7,614
Missouri	20,657	4,921	0	25,578
Montana	4,763	3,467	0	8,230
Nebraska	18,705	4,237	0	22,942
Nevada	7,012	1,439	0	8,451
New Hampshire	3,783	1,274	0	5,057
New Jersey	22,469	7,189	0	29,658
New Mexico	10,159	2,832	3	12,994
New York	117,688	43,618	0	161,306 A
North Carolina	20,892	4,875	9	25,776
North Dakota	1,412	563	0	1,975
Ohio	12,938	4,064	0	17,002
Oklahoma	7,963	2,200	0	10,163
Oregon	23,896	6,978	0	30,874
Pennsylvania	26,535	6,667	0	33,202
Puerto Rico	6,331	333	0	6,664
Rhode Island	6,836	3,238	0	10,074
South Carolina	21,892	4,258	876	27,026
South Dakota	2,956	1,266	0	4,222
Tennessee	6,516	1,787	0	8,303
Texas	11,839	4,086	0	15,925
Utah	10,842	1,770	0	12,612
Vermont	2,469	763	0	3,232
Virginia	28,091	7,923	0	36,014
Washington	N/A	N/A	0	N/A
West Virginia	10,019	1,770	0	11,789
Wisconsin	55,789	18,365	0	74,154
Wyoming	N/A	N/A	0	N/A
TOTALS	955,807	267,226	9,886	1,232,919
PERCENT OF TOTAL	77.5%	21.7%	.8%	100.0%

A = All client admissions data are estimated.

N/A = Information not available.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

TABLE 12

NUMBER OF ALCOHOL CLIENT TREATMENT ADMISSIONS BY AGE AND STATE FOR FISCAL YEAR 1989

STATE	UNDER AGE 18	18 TO 20	21 TO 24	25 TO 34	35 TO 44	45 TO 54	55 TO 64	AGE 65 AND OVER	NOT REPORTED	TOTAL	
Alabama	139	374	640	2,707	1,896	828	370	119	235	7,308	
Alaska	581	564	1,006	3,182	2,162	870	484	111	0	8,960	
Arizona	942	849	1,705	6,527	4,878	2,258	921	378	0	18,458	
Arkansas	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	7,512	7,512	
California	2,519	3,506	9,532	40,429	33,307	13,257	5,478	1,534	0	109,562	
Colorado	1,325	2,690	5,079	19,636	14,574	6,759	3,281	1,102	0	54,446	
Connecticut	192	544	1,896	4,523	3,007	1,696	637	0	4,816	17,311	A
Delaware	9	113	261	1,347	909	424	190	133	0	3,386	
District of Col	22	225	506	2,173	1,463	844	338	56	0	5,627	
Florida	2,223	3,567	4,757	18,611	16,583	7,499	3,246	960	0	57,446	
Georgia	372	906	2,303	10,282	8,734	5,401	2,590	718	0	31,306	
Guam	5	2	10	24	26	2	2	0	0	71	
Hawaii	481	46	215	616	474	305	97	17	31	2,282	
Idaho	862	240	579	1,514	933	391	159	44	0	4,722	
Illinois	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	48,508	48,508	
Indiana	562	957	1,754	4,470	2,645	1,022	395	131	0	11,936	
Iowa	1,329	2,170	2,837	6,608	3,271	1,244	567	211	274	18,511	
Kansas	455	835	1,513	4,138	2,061	765	359	163	5	10,294	
Kentucky	706	863	1,439	4,552	2,698	1,344	601	166	3,875	16,244	
Louisiana	185	314	609	2,396	1,522	625	204	54	0	5,909	
Maine	438	243	2,156	5,512	1,770	1,309	353	177	2,004	13,962	
Maryland	1,467	1,149	2,398	7,216	3,705	1,392	639	202	4	18,172	
Massachusetts	1,451	3,126	7,466	22,679	15,010	7,208	3,457	1,278	0	61,675	
Michigan	2,705	2,306	4,433	13,924	7,363	2,936	1,109	345	288	35,409	
Minnesota	1,872	2,601	4,121	16,615	14,198	7,440	3,933	1,871	414	53,065	
Mississippi	168	492	1,055	3,228	1,640	683	268	80	0	7,614	
Missouri	955	1,192	2,668	9,561	6,054	3,137	1,690	317	4	25,578	
Montana	753	608	893	1,167	3,061	982	529	237	0	8,230	
Nebraska	1,389	1,747	2,402	7,030	5,352	2,847	1,685	490	0	22,942	
Nevada	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	8,451	8,451	
New Hampshire	128	366	622	2,140	1,107	415	164	58	57	5,057	
New Jersey	2,214	1,852	3,720	11,946	6,330	2,268	944	342	42	29,658	
New Mexico	1,203	912	1,656	4,469	2,758	1,258	507	228	3	12,994	
New York	8,065	4,838	17,744	43,553	41,940	22,583	19,357	3,226	0	161,306	B
North Carolina	600	1,186	2,686	9,902	6,168	3,227	1,475	523	9	25,776	
North Dakota	58	141	240	793	412	184	109	37	1	1,975	
Ohio	961	1,079	1,878	7,382	3,690	1,362	478	172	0	17,002	
Oklahoma	516	674	1,100	3,681	2,367	1,196	492	137	0	10,163	
Oregon	2,110	2,052	3,560	10,806	6,766	2,791	2,338	451	0	30,874	
Pennsylvania	1,921	1,984	3,743	12,651	7,470	3,441	1,547	445	0	33,202	
Puerto Rico	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	6,664	6,664	
Rhode Island	158	171	408	1,026	690	118	27	10	7,466	10,074	
South Carolina	1,236	1,363	2,611	9,317	6,805	3,528	1,534	632	0	27,026	
South Dakota	588	460	502	1,324	782	334	154	78	0	4,222	
Tennessee	611	558	967	3,426	1,769	685	230	57	0	8,303	
Texas	508	486	995	3,766	2,448	1,209	558	125	5,830	15,925	
Utah	703	722	1,241	4,028	3,342	1,560	824	180	12	12,612	
Vermont	208	236	371	1,146	725	388	122	36	0	3,232	
Virginia	2,161	1,802	3,638	12,641	6,735	4,646	2,486	540	1,365	36,014	
Washington	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
West Virginia	768	858	1,795	3,795	2,497	1,394	510	172	0	11,789	
Wisconsin	2,661	5,161	10,231	26,442	16,167	7,636	3,967	1,889	0	74,154	
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
TOTALS	51,485	59,130	123,941	394,901	280,264	133,691	71,405	20,232	97,870	1,232,919	
PERCENT OF TOTAL	4.2%	4.8%	10.1%	32.0%	22.7%	10.8%	5.8%	1.6%	7.9%	100.0%	

Note: A number of the States that have the N/A designation collect age related information but not according to the specific age categories shown above.

A = Age 21 to 24 category includes Age 21 to 25, Age 25 to 34 category includes Age 26 to 35, Age 35 to 44 category includes Age 36 to 45, Age 45 to 54 category includes Age 46 to 59, Age 55 to 64 category is eliminated, and Age 65 and Over category includes Age 60 and Over.

B = All client admissions data are estimated.

N/A = Information not available.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

With regard to alcohol client treatment admissions information by age and by sex, a total of forty-one State Agencies, the District of Columbia and Guam reported at least some relevant data (see Table 13). A number of States have established different age range categories, and they were not able to retrieve or report client information according to some or all of the specific categories requested by NASADAD. The data shown indicates that the male/female ratio increases as age increases. The male/female mix is 64 percent/36 percent in the lowest age group of under 18 and increases steadily to a high of 82 percent male in the highest age group of 65 and over.

With regard to alcohol client treatment admissions information by race/ethnicity, a total of forty-eight State Agencies, the District of Columbia, Guam and Puerto Rico provided at least partial data (see Table 14). Among the States reporting data, the percents of client admissions that fell within the race/ethnicity categories specified were as follows:

Race/Ethnicity	Percent of Admissions
White, not of Hispanic origin	69.7%
Black, not of Hispanic origin	17.2%
Hispanic	6.4%
Asian of Pacific Islander	.2%
Native American (American Indian or Alaskan Native)	3.8%
Other	.7%
Not Reported	2.1%

Since several of the State Agencies reported data in some categories but not in others, caution should be exercised in the interpretation and use of the percent information noted above for both age and race/ethnicity.

In addition, States were asked to estimate the percent of alcohol client admissions who have secondary other drug problems. Responses to this request were received from forty-one States, the District of Columbia and Guam (see Table 15). The percent of alcohol client admissions that were estimated to have dual addiction problems ranged widely and to some extent this variation probably reflects real differences across States. Most States estimated such dual addiction problems in the range of from 30 percent to 60 percent. Due to the wide range of estimates it is clear that further work on this question is required in the future, in order to obtain more valid, and reliable responses from some of the States.

NUMBER OF ALCOHOL CLIENT TREATMENT ADMISSIONS BY AGE, BY SEX, AND BY STATE FOR FISCAL YEAR 1989

STATE	UNDER AGE 18				18 TO 20				21 TO 24				25 TO 34				35 TO 44			
	MALE	FEMALE	HH	TOTAL	MALE	FEMALE	HH	TOTAL	MALE	FEMALE	HH	TOTAL	MALE	FEMALE	HH	TOTAL	MALE	FEMALE	HH	TOTAL
Alabama	90	49		139	202	72		274	488	152		640	2,034	673		2,707	1,305	511		1,816
Alaska	134	157		291	413	132		544	738	268		1,006	2,336	846		3,182	1,847	875		2,722
Arizona	492	450		942	630	219		849	1,303	402		1,705	4,810	1,717		6,527	3,666	1,212		4,878
Arkansas	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A
California	1,423	1,096		2,519	2,329	986		3,306	7,122	2,410		9,532	30,349	10,980		40,429	26,514	6,793		33,307
Colorado	942	383		1,325	2,184	536		2,690	4,084	995		5,079	15,617	4,019		19,636	12,296	2,278		14,574
Connecticut	125	67		192	447	97		544	1,537	359		1,896	3,763	760		4,523	2,957	410		3,367
Delaware	9	0		9	87	26		113	207	54		261	1,184	363		1,547	766	143		909
District of Col	19	3		22	196	39		235	641	65		806	1,891	282		2,173	1,273	190		1,463
Florida	N/A	N/A	2,223	2,223	N/A	N/A	3,567	3,567	N/A	N/A	4,757	4,757	N/A	N/A	18,611	18,611	N/A	N/A	16,583	16,583
Georgia	282	90		372	750	156		906	1,990	413		2,383	7,991	2,231		10,222	7,203	1,831		9,734
Guam	4	1		5	1	1		2	8	2		10	19	5		24	21	5		26
Hawaii	263	218		481	20	26		46	158	57		215	480	136		616	367	57		424
Idaho	N/A	N/A	862	862	N/A	N/A	240	240	N/A	N/A	579	579	N/A	N/A	1,814	1,814	N/A	N/A	933	933
Illinois	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A
Indiana	N/A	N/A	842	842	N/A	N/A	997	997	N/A	N/A	1,784	1,784	N/A	N/A	4,478	4,478	N/A	N/A	2,643	2,643
Iowa	744	585		1,329	1,629	541		2,170	2,344	493		2,837	5,282	1,226		6,508	2,498	773		3,271
Kansas	367	148		485	709	126		835	1,354	359		1,513	3,368	770		4,138	1,716	345		2,061
Kentucky	484	222		706	713	150		863	1,187	252		1,439	3,649	903		4,552	2,179	819		2,998
Louisiana	185	80		185	214	100		314	490	119		609	1,833	541		2,396	1,192	290		1,482
Maine	314	124		438	195	48		243	1,473	683		2,156	4,332	1,160		5,512	1,267	483		1,750
Maryland	1,187	360		1,467	930	219		1,149	1,877	521		2,398	5,642	1,574		7,216	2,999	706		3,705
Massachusetts	949	502		1,451	2,573	553		3,126	6,174	1,292		7,466	18,752	3,827		22,579	12,838	2,172		15,010
Michigan	1,787	998		2,785	1,848	458		2,306	3,829	904		4,433	10,752	3,172		13,924	5,735	1,638		7,373
Minnesota	1,271	601		1,872	2,047	554		2,601	3,271	850		4,121	13,496	3,129		16,615	12,080	2,118		14,198
Mississippi	126	42		168	413	79		492	940	115		1,055	2,710	518		3,228	1,360	280		1,640
Missouri	534	421		955	924	268		1,192	2,187	561		2,668	7,519	2,042		9,561	5,040	1,014		6,054
Montana	374	379		753	393	215		608	556	337		893	680	487		1,167	1,725	1,336		3,061
Nebraska	835	534		1,389	1,908	439		1,747	1,947	555		2,402	5,647	1,383		7,030	4,808	764		5,572
Nevada	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A
New Hampshire	78	50		128	256	110		366	445	177		622	1,628	512		2,140	839	260		1,107
New Jersey	1,524	690		2,214	1,464	368		1,832	2,648	1,072		3,720	8,900	3,046		11,946	8,949	1,282		6,231
New Mexico	833	370		1,203	726	186		912	1,343	313		1,656	3,982	967		4,469	2,160	598		2,758
New York	4,920	3,145		8,065	3,532	1,306		4,838	12,983	4,791		17,744	32,645	10,988		43,353	30,291	11,649		41,940
North Carolina	438	162		600	939	247		1,186	2,855	631		2,686	7,790	2,112		9,902	5,189	979		6,168
North Dakota	30	28		58	81	60		141	177	63		240	843	230		783	300	113		413
Ohio	731	230		961	821	258		1,079	1,439	449		1,878	5,618	1,764		7,382	2,998	882		3,880
Oklahoma	381	165		546	830	184		674	893	207		1,100	2,822	880		3,681	1,863	804		2,667
Oregon	N/A	N/A	2,110	2,110	N/A	N/A	2,852	2,852	N/A	N/A	3,560	3,560	N/A	N/A	10,806	10,806	N/A	N/A	6,766	6,766
Pennsylvania	1,292	629		1,921	1,894	390		1,984	3,009	734		3,743	10,800	3,643		13,651	6,128	1,350		7,478
Puerto Rico	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A
Rhode Island	91	67		158	130	41		171	288	128		488	720	306		1,026	496	194		690
South Carolina	916	310	10	1,236	1,145	186	52	1,383	2,186	383	72	2,611	7,483	1,834	330	9,317	5,482	1,026	327	6,835
South Dakota	412	176		588	322	138		460	261	131		592	927	297		1,224	847	235		782
Tennessee	450	161		611	646	112		558	789	298		967	2,679	747		3,426	2,388	381		1,768
Texas	378	130		508	385	101		486	807	188		995	3,095	671		3,766	2,050	398		2,448
Utah	482	251		733	687	116		722	1,053	188		1,241	3,422	606		4,028	2,978	372		3,350
Vermont	144	64		208	191	45		236	291	80		371	998	268		1,146	882	173		725
Virginia	1,495	786		2,161	1,369	433		1,802	2,809	829		3,638	9,868	2,773		12,641	8,438	1,297		6,735
Washington	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A
West Virginia	525	243		768	576	182		858	1,482	313		1,795	3,278	817		3,795	2,182	395		2,577
Wisconsin	1,589	1,152		2,661	3,758	1,403		5,161	7,942	2,289		10,231	20,831	6,411		26,642	12,149	4,018		16,167
Wyoming	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A
TOTALS	29,429	16,209	5,767	51,405	40,377	11,883	6,868	59,130	87,814	25,304	10,723	123,941	278,965	79,285	35,731	394,901	200,864	52,146	27,284	280,294

See footnotes at the bottom of next page.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

NUMBER OF ALCOHOL CLIENT TREATMENT ADMISSIONS BY AGE, BY SEX, AND BY STATE FOR FISCAL YEAR 1989

	45 to 54				55 TO 64				65 and OVER				NOT REPORTED				TOTALS			
	MALE	FEMALE	NR	TOTAL	MALE	FEMALE	NR	TOTAL	MALE	FEMALE	NR	TOTAL	MALE	FEMALE	NR	TOTAL	MALE	FEMALE	NR	TOTAL
[illegible]bama	626	283		828	282	88		370	95	24		119	162	73		233	5,463	1,845	0	7,308
Alaska	639	231		870	255	129		404	86	25		111	0	0		0	6,877	2,303	0	9,960
Arizona	1,687	571		2,258	748	173		921	310	68		378	0	0		0	13,646	4,812	0	18,458
[illegible]nsas	N/A	N/A		0	N/A	N/A		0	N/A	N/A		0	6,334	1,178		7,512	6,334	1,178	0	7,512
[illegible]lifornia	10,986	2,301		13,257	4,711	767		5,478	1,313	213		1,534	0	0		0	84,910	24,652	0	109,562
[illegible]olorado	2,879	600		6,789	2,917	364		3,281	987	113		1,102	0	0		0	44,676	9,870	0	54,546
Connecticut	1,473	223		1,696	846	91		837	0			0	N/A	N/A	4,816	4,816	10,480	2,007	4,816	17,311
[illegible]laware	366	68		434	184	36		190	124	9		133	0	0		0	3,817	869	0	3,306
District of Col	725	199		844	294	44		338	49	7		56	0	0		0	4,980	729	0	5,627
[illegible]rida	N/A	N/A	7,499	7,499	N/A	N/A	3,246	3,246	N/A	N/A	960	960				0	44,678	12,776	0	87,646
[illegible]rgia	4,542	659		5,681	2,165	423		2,590	618	100		718				0	25,433	5,873	0	31,306
[illegible]m	1	1		2	2	0		2	0	0		0	0	0		0	54	15	0	71
[illegible]waii	288	67		355	76	19		97	15	2		17	22	9		31	1,681	501	0	2,282
[illegible]ho	N/A	N/A	301	301	N/A	N/A	139	139	N/A	N/A	44	44				0	3,657	1,065	0	4,722
Illinois	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	36,864	10,853	781	48,498	36,864	10,853	781	48,498
Indiana	N/A	N/A	1,822	1,822	N/A	N/A	396	396	N/A	N/A	131	131				0	8,871	2,663	0	11,534
[illegible]wa	867	287		1,244	462	185		647	177	34		211	181	83		274	14,294	4,237	0	18,811
[illegible]nsas	632	133		765	321	38		359	155	8		163	4	1		5	8,466	1,828	0	10,294
[illegible]ntucky	1,109	235		1,344	533	78		611	125	41		166	618	290	3,977	3,975	10,567	2,690	3,977	16,244
Louisiana	482	143		625	160	44		204	43	12		54	0	0		0	4,840	1,369	0	6,209
[illegible]ine	1,023	2 [illegible]		1,309	274	79		353	134	43		177	1,313	691		2,004	10,445	3,317	0	13,962
[illegible]ryland	1,171	231		1,393	561	78		639	179	23		202	3	1		4	14,469	3,703	0	18,172
[illegible]ssachusetts	6,235	973		7,208	3,027	430		3,457	1,137	141		1,278				288	37,291	8,118	0	33,409
Michigan	2,332	604		2,936	895	214		1,289	271	74		345	222	64		414	43,730	8,821	414	53,965
Minnesota	6,526	914		7,440	3,433	500		3,933	1,616	255		1,871	N/A	N/A	414	414	6,497	1,307	0	7,614
[illegible]ssissippi	559	134		693	230	38		268	69	11		80	0	0		4	30,657	4,921	0	35,578
Missouri	2,793	434		3,227	1,533	157		1,690	293	34		317	4	0		4	4,763	3,467	0	8,230
[illegible]ntana	578	484		962	311	218		529	166	81		237	0	0		0	18,788	4,237	0	22,542
Nebraska	2,642	486		3,047	1,575	118		1,685	443	47		490	0	0		0	7,012	1,439	0	8,451
[illegible]vada	N/A	N/A		0	N/A	N/A		0	N/A	N/A		0	7,012	1,439		8,451	7,012	1,439	0	8,451
New Hampshire	314	101		415	135	29		164	43	13		56	45	12		57	3,763	1,274	0	5,057
New Jersey	1,835	433		2,268	772	172		944	244	98		342	34	8		42	21,468	7,189	0	28,658
New Mexico	981	277		1,258	423	84		507	191	37		228	N/A	N/A	3	3	10,128	3,832	3	13,964
New York	16,486	6,097		22,583	14,131	5,236		19,367	3,710	516		3,226	0	0		0	117,688	43,618	0	161,306
North Carolina	3,783	434		3,227	1,364	211		1,475	434	99		533	0	0	9	9	20,092	4,678	9	28,774
North Dakota	149	39		184	62	27		189	29	8		37	1	0		1	1,413	563	0	1,978
Ohio	1,036	326		1,362	364	114		478	121	41		172				0	12,836	4,064	0	17,902
Oklahoma	972	223		1,196	425	67		492	116	21		137				0	7,963	2,290	0	10,163
Oregon	N/A	N/A	2,781	2,781	N/A	N/A	2,338	2,338	N/A	N/A	481	481				0	23,894	6,978	0	30,874
Pennsylvania	2,849	892		3,441	1,388	241		1,847	363	82		445	0	0		0	26,833	6,667	0	33,202
Puerto Rico	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	6,331	333		6,664	6,331	333	0	6,664
Rhode Island	98	30		118	15	12		27	6	4		10	5,802	2,464		7,466	6,834	3,230	0	10,074
South Carolina	2,930	542	84	3,529	1,386	288	28	1,834	535	97	0	632	0	0		0	21,892	6,290	576	27,026
South Dakota	234	100		334	108	46		154	56	23		78	0	0		0	2,956	1,266	0	4,222
Tennessee	563	122		685	189	41		230	62	15		87				0	6,516	1,787	0	8,303
Texas	1,036	173		1,209	483	78		560	109	16		125	3,496	2,334		5,830	11,838	4,986	0	16,823
Utah	1,416	164		1,580	754	68		824	150	22		190	8	4		12	10,942	1,770	0	12,612
Vermont	285	183		288	63	39		122	25	11		36	0	0		0	2,469	763	0	3,232
Virginia	3,709	937		4,646	2,017	469		2,486	432	106		548	1,844	321		1,363	30,991	7,923	0	36,814
Washington	N/A	N/A		N/A	N/A	N/A		0	N/A	N/A		0	N/A	N/A		N/A	N/A	N/A	0	N/A
West Virginia	1,367	127		1,394	434	86		519	145	27		173	0	0		0	18,819	1,770	0	11,789
Wisconsin	5,704	1,932		7,636	3,190	777		3,967	1,986	263		1,989				0	58,789	15,365	0	74,154
Wyoming	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A	0	N/A
TOTALS	98,886	23,374	11,789	133,691	53,884	13,185	6,166	71,485	15,642	3,884	1,886	20,232	68,710	20,180	9,810	97,870	953,887	267,226	9,886	1,232,319

Note: A number of the States that have the N/A designation collect age-related information but not according to the specific age categories shown above.

A = Alcohol client admissions data are estimated.

N/A = Information not available.
NR = Not Reported.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

TABLE 14

NUMBER OF ALCOHOL CLIENT TREATMENT ADMISSIONS BY RACE/ETHNICITY AND STATE FOR FISCAL YEAR 1989

STATE	WHITE, NOT OF HISPANIC ORIGIN	BLACK, NOT OF HISPANIC ORIGIN	HISPANIC	ASIAN OR PACIFIC ISLANDER	NATIVE AMERICAN	OTHER	NOT REPORTED	TOTAL	
Alabama	5,255	1,785	N/A	N/A	N/A	33	235	7,308	
Alaska	3,855	123	98	24	4,467	248	145	8,960	
Arizona	11,417	869	3,136	84	2,952	0	0	18,458	
Arkansas	5,835	1,605	N/A	N/A	N/A	72	0	7,512	
California	70,556	24,542	10,847	549	2,082	986	0	109,562	
Colorado	33,389	3,562	13,398	N/A	2,658	160	1,279	54,446	
Connecticut	8,955	2,661	832	N/A	N/A	46	4,817	17,311	
Delaware	2,449	874	63	N/A	N/A	N/A	N/A	3,386	
District of Col	393	5,002	112	46	17	57	0	5,627	
Florida	44,614	9,278	3,308	74	172	0	0	57,446	
Georgia	21,863	9,290	79	18	19	37		31,306	
Guam	18	0	1	51	0	1	0	71	
Hawaii	1,101	48	71	731	214	59	58	2,282	
Idaho	4,008	34	406	8	232	34	0	4,722	
Illinois	28,926	16,366	2,499	102	97	124	394	48,508	
Indiana	9,586	2,151	154	6	14	25	0	11,936	
Iowa	17,270	500	259	30	221	31	200	18,511	
Kansas	8,235	1,030	592	25	350	18	44	10,294	
Kentucky	11,880	1,118	N/A	N/A	N/A	50	3,196	16,244	A
Louisiana	3,766	2,031	87	8	17	0	0	5,909	
Maine	13,100	21	N/A	20	412	129	280	13,962	
Maryland	11,665	6,336	N/A	N/A	N/A	171	0	18,172	B
Massachusetts	53,997	4,469	2,287	125	438	359	0	61,675	
Michigan	29,048	4,428	938	30	781	74	110	35,409	
Minnesota	36,188	3,492	1,200	67	11,368	93	657	53,065	
Mississippi	4,366	3,224	0	0	24	0	0	7,614	
Missouri	17,811	7,291	254	11	211	0	0	25,578	
Montana	6,833	14	114	7	1,239	23	0	8,230	
Nebraska	16,842	1,185	872	23	3,916	41	63	22,942	
Nevada	6,498	1,079	356	7	419	92	0	8,451	
New Hampshire	4,425	46	21	4	12	44	505	5,057	
New Jersey	16,854	10,140	2,414	0	76	88	86	29,658	
New Mexico	3,483	200	4,941	15	4,355	0	0	12,994	
New York	100,638	42,243	13,248	N/A	923	4,254	0	161,306	
North Carolina	15,929	9,289	75	N/A	363	70	50	25,776	
North Dakota	1,705	2	7	4	237	3	17	1,975	
Ohio	12,701	4,046	187	34	34	0	0	17,002	
Oklahoma	7,820	906	218	11	1,208	0	0	10,163	
Oregon	26,227	855	1,673	149	1,970	0	0	30,874	
Pennsylvania	26,312	6,108	694	37	N/A	51	0	33,202	
Puerto Rico	0	0	6,664	0	0	0	0	6,664	
Rhode Island	2,134	241	154	6	16	57	7,466	10,074	
South Carolina	19,075	7,808	86	24	33	0	0	27,026	
South Dakota	3,061	34	0	0	1,093	34	0	4,222	
Tennessee	6,783	1,479	24	3	5	8	1	8,303	
Texas	5,873	1,257	2,827	9	133	0	5,826	15,925	
Utah	8,970	228	1,379	76	1,858	24	77	12,612	
Vermont	3,232	N/A	N/A	N/A	N/A	N/A	N/A	3,232	
Virginia	25,210	8,644	685	72	72	649	682	36,014	
Washington	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
West Virginia	10,742	1,033	10	2	2	0	0	11,789	
Wisconsin	68,488	2,499	1,103	349	1,715	0	0	74,154	
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
TOTALS	859,381	211,466	78,373	2,841	46,425	8,245	26,188	1,232,919	
PERCENT OF TOTAL	69.7%	17.2%	6.4%	.2%	3.8%	.7%	2.1%	100.0%	

A = "Other" category includes "Hispanic", "Asian or Pacific Islander", and "Native American" admissions.
B = All non-White, non-Black categories are grouped in the "Other" category.

N/A = Information not available.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

TABLE 15

ESTIMATED PERCENT OF ALCOHOL CLIENT ADMISSIONS
WHO HAVE SECONDARY OTHER DRUG PROBLEMS

STATE	PERCENT	
Alabama	N/A	
Alaska	36.1	
Arizona	N/A	
Arkansas	36.0	
California	N/A	
Colorado	23.0	
Connecticut	66.4	
Delaware	12.0	
District of Col	40.0	
Florida	40.0	
Georgia	50.0	
Guam	7.0	
Hawaii	80.0	
Idaho	N/A	
Illinois	65.0	
Indiana	10.9	
Iowa	52.0	
Kansas	40.0	
Kentucky	N/A	
Louisiana	82.0	
Maine	67.0	
Maryland	43.0	
Massachusetts	22.4	
Michigan	45.0	
Minnesota	12.0	
Mississippi	73.0	
Missouri	21.1	
Montana	30.0	
Nebraska	60.0	
Nevada	25.0	
New Hampshire	42.0	
New Jersey	54.0	
New Mexico	88.8	
New York	6.0	
North Carolina	57.0	
North Dakota	18.0	
Ohio	N/A	
Oklahoma	30.2	
Oregon	39.6	A
Pennsylvania	42.0	
Puerto Rico	N/A	
Rhode Island	64.0	B
South Carolina	13.2	
South Dakota	N/A	
Tennessee	30.0	
Texas	37.6	
Utah	29.6	
Vermont	5.0	
Virginia	28.0	
Washington	N/A	
West Virginia	33.0	
Wisconsin	42.0	
Wyoming	N/A	

N/A = Information not available.

A = Includes 48% Driving Under the Influence clients which tend to be alcohol only.
B = Does not include missing/unknown information.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

3. Drug Client Admissions Data by Sex, Age, Race/Ethnicity and Dual Addiction Problems (Table 16, 17, 18 19, and 20)

Each State Drug (and combined Alcohol and Drug) Agency was asked to provide data on "the number of DRUG treatment client admissions during FY 1989" in all units "which received at least some funds administered by the State Drug Agency" in each of a number of specific sex, age, race/ ethnicity and dual addiction categories.

Forty-eight States, the District of Columbia and Guam reported drug client admissions data by sex (see Table 16). Overall, 65.7 percent of the drug client admissions were male, 32.3 percent were female, and data on sex were not reported for 2.0 percent of the drug client admissions.

Forty-five State Agencies, the District of Columbia, Guam, and Puerto Rico provided at least partial information on drug client admissions by age (see Table 17). The proportions of client admissions that fell within the age-range categories requested were as follows:

Age	Percent of Admissions
Under 18	12.6%
18-20	7.8%
21-24	13.3%
25-34	38.5%
35-44	16.2%
45-54	3.2%
55-64	.8%
65 and over	.3%
Not reported	7.3%

However, these specific percents should be interpreted with caution since one State reported admissions by age categories that were similar but not precisely the same.

In comparing total drug admissions by age with total alcohol client admissions by age, it is clear that the drug clients tend to be much younger, while the alcohol clients tend to be older (e.g., 20.4% of drug clients are under 21 years of age compared to only 9.0% of alcohol clients).

With regard to drug client treatment admissions by age and sex, a total of 43 States, the District of Columbia and Guam provided at least partial data according to the age categories specified (see Table 18). A number of States encountered problems in reporting client admissions data by

TABLE 16

NUMBER OF DRUG CLIENT TREATMENT ADMISSIONS
BY SEX AND STATE FOR FISCAL YEAR 1989

	SEX			
STATE	MALE	FEMALE	NOT REPORTED	TOTAL
Alabama	3,405	1,976	0	5,381
Alaska	1,253	610	0	1,863
Arizona	4,606	2,919	0	7,525
Arkansas	2,513	1,087	0	3,600
California	37,835	26,143	0	63,978
Colorado	3,083	1,519	0	4,602
Connecticut	5,235	1,713	1,501	8,449
Delaware	1,341	536	0	1,877
District of Col	4,303	1,934	0	6,237
Florida	17,939	7,454	0	25,393
Georgia	17,106	6,937	0	24,043
Guam	5	2	0	7
Hawaii	1,302	724	0	2,026
Idaho	1,409	816	0	2,225
Illinois	24,453	7,201	517	32,171
Indiana	5,204	1,644	0	6,848
Iowa	3,241	1,395	0	4,636
Kansas	2,976	1,006	0	3,982
Kentucky	3,519	1,472	1,120	6,111
Louisiana	5,327	1,982	0	7,309
Maine	3,633	1,362	0	4,995
Maryland	13,495	4,339	0	17,834
Massachusetts	24,075	10,714	0	34,789
Michigan	15,276	9,368	0	24,644
Minnesota	7,795	3,005	0	10,800
Mississippi	2,564	1,216	0	3,780
Missouri	6,982	2,397	0	9,379
Montana	1,489	660	0	2,149
Nebraska	1,573	988	0	2,561
Nevada	1,289	859	0	2,148
New Hampshire	747	384	0	1,131
New Jersey	9,298	4,358	0	13,656
New Mexico	2,073	1,013	0	3,086
New York	50,390	35,514	0	85,904
North Carolina	3,548	1,470	1	5,019
North Dakota	429	221	0	650
Ohio	13,634	7,628	23	21,285
Oklahoma	2,987	1,895	0	4,882
Oregon	5,397	3,658	0	9,055
Pennsylvania	22,292	10,216	0	32,508
Puerto Rico	N/A	N/A	9,184	9,184
Rhode Island	2,981	1,616	0	4,597
South Carolina	5,752	2,230	0	7,982
South Dakota	2,624	1,126	0	3,750
Tennessee	5,332	2,190	0	7,522
Texas	10,826	4,267	0	15,093
Utah	2,105	979	0	3,084
Vermont	1,632	658	0	2,290
Virginia	12,956	6,439	0	19,395
Washington	N/A	N/A	0	N/A
West Virginia	1,206	513	0	1,719
Wisconsin	17,453	5,327	0	22,780
Wyoming	N/A	N/A	0	N/A
TOTALS	397,888	195,680	12,346	605,914
PERCENT OF TOTAL	65.7%	32.3%	2.0%	100.0%

N/A = Information not available.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

TABLE 17

NUMBER OF DRUG CLIENT TREATMENT ADMISSIONS BY AGE AND STATE FOR FISCAL YEAR 1989

STATE	UNDER AGE 18	18 TO 20	21 TO 24	25 TO 34	35 TO 44	45 TO 54	55 TO 64	AGE 65 AND OVER	NOT REPORTED	TOTAL
Alabama	215	422	648	2,481	1,005	179	74	85	272	5,381
Alaska	318	172	307	659	342	36	22	7	0	1,863
Arizona	1,065	511	924	2,979	1,634	308	75	28	0	7,525
Arkansas	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3,600	3,600
California	3,997	3,768	8,089	27,969	16,204	3,131	715	105	0	63,978
Colorado	614	358	517	1,916	947	202	34	14	0	4,602
Connecticut	263	656	1,478	3,274	1,151	110	16	0	1,501	8,449 A
Delaware	11	159	323	988	355	39	2	0	0	1,877
District of Col	80	374	748	2,370	1,559	935	125	46	0	6,237
Florida	3,086	2,252	3,907	11,625	3,809	545	135	34	0	25,393
Georgia	588	1,863	4,439	12,863	3,727	436	92	35	0	24,043
Guam	2	1	0	1	2	1	0	0	0	7
Hawaii	534	120	238	564	357	119	30	9	55	2,026
Idaho	621	165	272	705	290	95	58	19	0	2,225
Illinois	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	32,171	32,171
Indiana	322	549	1,006	2,565	1,517	586	228	75	0	6,848
Iowa	461	619	818	1,931	625	65	20	6	91	4,636
Kansas	248	472	774	1,908	497	49	15	19	0	3,982
Kentucky	562	582	746	1,959	708	153	55	18	1,328	6,111
Louisiana	682	685	1,347	3,607	816	137	35	N/A	0	7,309
Maine	203	109	885	1,780	634	240	97	80	967	4,995
Maryland	1,854	1,584	3,044	7,715	3,019	502	95	18	3	17,834
Massachusetts	2,277	2,555	5,715	16,325	6,582	980	261	94	0	34,789
Michigan	2,616	1,592	3,234	11,111	4,686	795	229	76	305	24,644
Minnesota	958	1,289	1,830	4,822	1,592	217	46	44	2	10,800
Mississippi	124	342	678	1,914	522	122	57	21	0	3,780
Missouri	510	1,028	1,789	4,547	1,324	138	34	3	6	9,379
Montana	363	293	425	415	596	33	18	6	0	2,149
Nebraska	412	328	358	976	346	91	35	15	0	2,561
Nevada	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2,148	2,148
New Hampshire	140	132	198	448	172	22	5	7	7	1,131
New Jersey	854	950	1,884	6,367	3,161	375	54	11	0	13,656
New Mexico	811	194	294	1,005	550	169	36	27	0	3,086
New York	34,366	7,347	8,362	23,160	10,472	1,728	340	64	65	85,904
North Carolina	557	515	703	2,246	840	124	25	8	1	5,019
North Dakota	40	62	93	325	102	18	6	4	0	650
Ohio	3,988	2,172	2,895	6,743	3,964	1,070	315	109	29	21,285
Oklahoma	351	511	815	2,356	694	106	30	19	0	4,882
Oregon	1,698	689	1,304	3,655	1,316	239	145	9	0	9,055
Pennsylvania	2,080	2,565	4,961	15,663	6,205	810	169	55	0	32,508
Puerto Rico	1,087	1,884	1,484	3,291	655	479	0	0	304	9,184
Rhode Island	361	264	564	1,425	750	18	14	6	1,195	4,597
South Carolina	799	614	1,174	3,827	1,245	203	53	67	0	7,982
South Dakota	522	409	446	1,176	694	297	137	69	0	3,750
Tennessee	800	696	1,221	3,554	1,028	177	33	13	0	7,522
Texas	910	1,378	2,552	6,990	2,714	441	81	19	8	15,093
Utah	459	284	439	1,246	477	100	43	35	1	3,084
Vermont	212	241	441	1,002	303	73	15	3	0	2,290
Virginia	1,766	1,572	2,599	8,243	3,259	1,222	408	97	229	19,395
Washington	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
West Virginia	364	238	286	505	220	84	14	8	0	1,719
Wisconsin	1,052	1,771	3,310	10,142	4,339	1,324	593	249	0	22,780
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTALS	76,203	47,336	80,564	233,338	98,006	19,323	5,120	1,736	44,288	605,914
PERCENT OF TOTAL	12.6%	7.8%	13.3%	38.5%	16.2%	3.2%	.8%	.3%	7.3%	100.0%

Note: A number of the States that have the N/A designation collect age related information but not according to the specific age categories shown above.

A = Age 21 to 24 category includes Age 21 to 25, Age 25 to 34 category includes Age 26 to 35, Age 35 to 44 category includes Age 36 to 45, Age 45 to 54 category includes Age 46 to 59, Age 55 to 64 category is eliminated and Age 65 and Over category includes Age 60 and Over.

N/A = Information not available.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

NUMBER OF DRUG CLIENT TREATMENT ADMISSIONS BY AGE, BY SEX, AND BY STATE FOR FISCAL YEAR 1989

STATE	UNDER AGE 18				18 TO 20				21 TO 24				25 TO 34				35 TO 44			
	MALE	FEMALE	NS	TOTAL	MALE	FEMALE	NS	TOTAL	MALE	FEMALE	NS	TOTAL	MALE	FEMALE	NS	TOTAL	MALE	FEMALE	NS	TOTAL
Alabama	122	93		215	312	110		422	469	179		648	1,554	925		2,481	629	376		1,00
Alaska	194	124		318	116	56		172	307	190		307	444	213		689	230	112		34
Arizona	648	417		1,065	399	112		511	558	366		924	1,706	1,273		2,979	1,033	681		1,63
Arkansas	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/
California	2,743	1,254		2,997	2,371	1,397		3,768	4,137	3,052		9,089	14,746	13,223		27,969	10,799	5,405		16,20
Colorado	435	179		614	274	84		358	345	172		517	1,193	723		1,916	669	278		94
Connecticut	202	61		263	557	99		656	1,060	320		1,478	2,392	982		3,374	906	245		1,15
Delaware	11	0		11	185	54		159	229	94		323	689	299		988	269	86		35
District of Col	85	29		90	258	116		374	516	232		748	1,636	734		2,370	1,076	403		1,55
Florida	2,180	906		3,086	1,891	661		2,252	2,760	1,147		3,907	8,213	3,412		11,625	2,691	1,118		3,80
Georgia	417	171		588	1,366	477		1,843	3,140	1,299		4,439	8,982	3,911		12,863	2,826	901		3,72
Guam	2	0		2	1	0		1	0	0		0	0	1		1	1	0		
Hawaii	223	211		534	74	46		120	137	101		238	346	218		564	298	99		39
Idaho	N/A	N/A	621	621	N/A	N/A	168	168	N/A	N/A	272	272	N/A	N/A	706	706	N/A	N/A	290	29
Illinois	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/
Indiana	N/A	N/A	322	322	N/A	N/A	549	549	N/A	N/A	1,006	1,006	N/A	N/A	2,963	2,963	N/A	N/A	1,817	1,81
Iowa	319	142		461	476	143		619	618	200		818	1,272	659		1,931	645	180		62
Kansas	189	89		348	375	97		472	572	202		774	1,481	587		1,988	380	117		49
Kentucky	499	153		562	441	141		582	571	175		746	1,213	646		1,869	494	214		70
Louisiana	541	121		682	499	186		685	978	369		1,347	2,839	1,007		3,687	646	170		81
Maine	148	55		203	88	21		109	612	273		885	1,383	397		1,780	482	152		63
Maryland	1,282	572		1,854	1,328	356		1,684	2,448	596		3,044	5,633	2,082		7,715	2,309	710		3,01
Massachusetts	1,445	832		2,277	1,065	690		2,555	3,760	1,965		5,715	11,072	5,259		16,325	4,996	1,586		6,58
Michigan	1,611	1,005		2,616	1,141	451		1,592	2,618	1,216		3,234	6,850	4,253		11,111	2,944	1,762		4,68
Minnesota	633	325		988	902	297		1,199	1,321	509		1,830	3,449	1,383		4,832	1,218	374		1,59
Mississippi	89	35		124	348	94		342	492	226		678	1,258	656		1,914	581	141		82
Missouri	367	143		510	804	224		1,028	1,336	451		1,789	3,232	1,215		4,847	1,064	320		1,33
Montana	245	118		363	228	65		293	309	116		425	277	138		615	399	157		59
Nebraska	292	120		412	222	106		328	216	142		358	688	348		976	175	171		34
Nevada	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/
New Hampshire	83	57		140	90	42		132	130	89		198	307	141		448	185	67		17
New Jersey	697	157		854	729	221		950	1,269	615		1,884	3,982	2,365		6,347	2,206	875		3,16
New Mexico	557	254		811	143	51		194	214	99		294	642	363		1,005	361	199		55
New York	16,761	17,685		34,366	4,271	2,976		7,247	5,236	3,128		8,362	14,762	8,398		23,160	7,689	2,863		10,47
North Carolina	434	123		557	484	111		615	482	221		703	1,496	748		2,244	635	215		84
North Dakota	25	15		40	36	26		62	68	25		93	222	103		325	69	33		10
Ohio	2,671	1,217		3,888	1,379	793		2,172	1,638	1,067		2,705	4,204	2,459		6,743	2,522	1,042		3,56
Oklahoma	241	110		351	241	170		511	510	305		815	1,388	968		2,356	432	352		69
Oregon	N/A	N/A	1,698	1,698	N/A	N/A	689	689	N/A	N/A	1,304	1,304	N/A	N/A	3,635	3,635	N/A	N/A	1,316	1,31
Pennsylvania	1,804	576		2,380	1,032	733		2,565	3,179	1,762		4,961	10,283	5,480		15,663	4,730	1,473		6,20
Puerto Rico	N/A	N/A	1,987	1,987	N/A	N/A	1,884	1,884	N/A	N/A	1,684	1,684	N/A	N/A	3,291	3,291	N/A	N/A	635	63
Rhode Island	239	122		361	197	67		264	382	212		594	885	530		1,415	492	238		73
South Carolina	398	201		799	470	144		614	864	320		1,174	2,787	1,139		3,927	923	322		1,24
South Dakota	265	157		522	296	123		409	313	134		446	823	383		1,176	486	200		69
Tennessee	280	220		800	547	149		696	992	329		1,321	3,473	1,981		5,554	712	316		1,02
Texas	727	183		910	1,814	364		1,178	1,794	758		2,552	4,770	2,220		6,990	2,974	648		3,71
Utah	326	133		459	224	60		284	311	138		439	814	432		1,246	315	162		47
Vermont	150	62		212	152	89		241	326	115		441	727	272		1,063	223	80		30
Virginia	1,261	505		1,766	1,145	427		1,572	1,668	931		2,599	5,263	2,880		8,243	2,182	1,067		3,25
Washington	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/
West Virginia	256	108		364	180	56		236	195	91		286	252	153		505	160	60		22
Wisconsin	783	269		1,052	1,419	352		1,771	2,422	888		3,310	7,907	2,845		10,142	3,439	900		4,33
Wyoming	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/
TOTALS	43,170	29,385	3,728	76,283	31,870	12,979	3,297	47,236	50,852	25,646	4,066	80,564	146,187	77,615	10,216	233,338	67,016	27,212	3,778	98,00

See footnotes at the bottom of next page.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

NUMBER OF DRUG CLIENT TREATMENT ADMISSIONS BY AGE, BY SEX, AND BY STATE FOR FISCAL YEAR 1989

STATE	45 to 54				55 TO 64				65 and OVER				NOT REPORTED				TOTALS			
	MALE	FEMALE	NR	TOTAL	MALE	FEMALE	NR	TOTAL	MALE	FEMALE	NR	TOTAL	MALE	FEMALE	NR	TOTAL	MALE	FEMALE	NR	TOTAL
Alabama	97	82		179	32	42		74	36	89		85	272	180		272	3,405	1,976	0	5,
Alaska	33	3		36	22	0		22	7	0		7				0	1,253	610	0	1,
Arizona	199	199		398	51	25		76	12	16		28	0	0		0	4,606	2,919	0	7,525
Arkansas	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	2,513	1,087		3,600	2,513	1,087	0	3,
California	2,406	725		3,131	554	161		715	79	26		105	0	0		0	37,835	26,143	0	63,
Colorado	139	63		202	19	15		34	9	5		14	0	0		0	3,083	1,319	0	4,
Connecticut	85	25		110	13	3		16				0	N/A	N/A	1,501	1,501	5,235	1,713	1,501	8,449 A
Delaware	26	13		39	2	0		2	0	0		0	0	0		0	1,341	536	0	1,877
District of Col	645	290		935	84	39		125	32	14		46				0	4,583	1,934	0	6,
Florida	385	160		545	98	40		138	24	10		34	0	0		0	17,928	7,454	0	25,
Georgia	317	119		436	55	37		92	13	22		35				0	17,184	6,837	0	24,
Guam	0	1		1	0	0		0	0	0		0	0	0		0	5	2	0	7
Hawaii	68	31		119	25	5		30	9	0		9	47	13		86	1,301	724	0	2,
Idaho	N/A	N/A		98	N/A	N/A		84	N/A	N/A		19				0	1,499	816	0	2,
Illinois	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	24,453	7,301	517	32,171	24,453	7,301	517	33,
Indiana	N/A	N/A	596	596	N/A	N/A	229	229	N/A	N/A	75	75	N/A	N/A	0	0	5,204	1,644	0	6,848
Iowa	39	26		65	7	13		20	2	4		6	63	28		91	3,841	1,395	0	4,636
Kansas	34	15		49	8	7		15	17	2		19	0	0		0	2,976	1,006	0	3,
Kentucky	98	55		153	33	22		55	9	9		18	151	57	1,120	1,328	3,819	1,472	1,120	6,
Louisiana	104	33		137	19	16		35	N/A	N/A		0	0	0		0	5,327	1,982	0	7,
Maine	170	70		240	62	35		97	60	20		80	638	329		967	3,433	1,362	0	4,995
Maryland	402	100		502	76	19		95	15	3		18	2	1		3	13,495	4,339	0	17,
Massachusetts	710	270		980	184	77		261	53	41		94				0	24,675	10,714	0	34,
Michigan	396	399		795	100	129		229	22	54		76	186	119		305	15,276	9,368	0	24,
Minnesota	151	65		217	26	20		46	22	22		44	2	0		2	7,795	3,003	0	10,800
Mississippi	74	48		122	46	11		57	16	5		21	0	0		0	2,564	1,216	0	3,780
Missouri	189	29		138	19	15		34	3	0		3	6	0		6	6,982	2,397	0	9,
Montana	18	15		33	11	7		18	2	4		6	0	0		0	1,489	660	0	2,
Nebraska	39	52		91	16	19		35	5	10		15	0	0		0	1,573	968	0	2,
Nevada	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	1,280	650		2,148	1,209	639	0	3,148
New Hampshire	13	0		22	4	1		5	0	7		7	6	1		7	747	384	0	1,
New Jersey	285	90		375	42	12		54	8	3		11				0	9,290	4,380	0	13,
New Mexico	114	55		169	22	14		36	20	7		27				0	2,073	1,013	0	3,
New York	1,328	400		1,728	239	101		340	47	17		64	37	28		65	50,380	35,514	0	85,904
North Carolina	97	27		124	13	12		25	7	1		8	N/A	N/A	1	1	3,548	1,470	1	5,019
North Dakota	7	11		18	1	5		6	1	3		4	0	0		0	429	221	0	
Ohio	678	392		1,070	195	120		315	65	44		109	2	4	23	29	13,634	7,630	23	21,
Oklahoma	61	45		106	10	20		30	4	15		19				0	2,987	1,895	0	4,
Oregon	N/A	N/A	239	239	N/A	N/A	145	145	N/A	N/A	9	9	N/A	N/A	0	0	5,297	3,658	0	9,955
Pennsylvania	639	171		810	125	44		169	28	27		55				0	22,291	10,216	0	32,
Puerto Rico	N/A	N/A	479	479	N/A	N/A		0	N/A	N/A		0	N/A	N/A	304	304	N/A	N/A	9,184	9,
Rhode Island	7	11		18	5	9		14	3	3		6	801	394		1,195	5,781	2,230	0	7,983
South Carolina	137	76		293	38	25		83	45	22		67	0	0		0	2,634	1,136	0	3,750
South Dakota	208	89		297	96	41		137	48	21		69	0	0		0	3,332	2,190	0	7,
Tennessee	105	72		177	16	17		33	7	6		13	0	0		0	5,331	2,190	0	7,
Texas	368	73		441	68	13		81	11	8		19	0	0		0	10,826	4,267	0	15,
Utah	87	43		130	33	10		43	25	10		35	0	1		1	2,101	979	0	3,
Vermont	42	31		73	11	4		15	1	2		3	0	0		0	1,632	658	0	2,290
Virginia	834	388		1,222	291	117		408	98	39		97	154	75		229	12,954	6,439	0	19,
Washington	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A	0	
West Virginia	53	31		84	6	8		14	4	4		8	0	0		0	1,206	513	0	1,
Wisconsin	1,060	344		1,324	304	89		393	209	40		249	0	0		0	17,453	5,327	0	22,780
Wyoming	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A	0	N/A
TOTALS	12,858	5,046	1,399	19,323	3,270	1,419	431	5,120	1,028	685	183	1,736	30,887	10,315	3,466	44,290	397,000	193,680	13,346	60,

Note: A number of the States that have the N/A designation collect age related information but not according to the specific age categories shown above.

A = Age 21 to 24 category includes Age 21 to 25, Age 25 to 34 category includes Age 26 to 35, Age 35 to 44 category includes Age 36 to 45, Age 45 to 54 category includes Age 46 to 55, Age 55 to 64 category is eliminated, and Age 65 and Over category includes Age 66 and Over.

N/A = Information not available.
NR = Not Reported.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

age and sex combined. The increased male ratio with increased age did not appear as strongly as with alcoholism clients. In fact, male drug client admissions represented 63.0 percent of those over age 65, while male alcohol client admissions represented 83.9 percent of alcohol admissions over age 65.

With regard to drug client treatment admissions information by race/ethnicity, a total of 48 States, the District of Columbia, Guam and Puerto Rico provided at least partial data (see Table 19). Among the States reporting data, the percents of client admissions that fell within the race/ethnicity categories specified were as follows:

Race/Ethnicity	Percent of Admissions
White, not of Hispanic origin	52.6%
Black, not of Hispanic origin	28.4%
Hispanic	10.2%
Asian or Pacific Islander	.5%
Native American (American Indian or Alaskan Native)	1.1%
Other	.3%
Not Reported	6.9%

A comparison of total drug client admissions with total alcohol client admissions in terms of race/ethnicity, indicates that drug clients include a higher proportion of Blacks, Hispanics, and Asian or Pacific Islanders. The alcohol clients include more Whites (69.7 percent compared to 52.6 percent among drug clients) and Native Americans (3.8 percent as compared to 1.1 percent among drug client admissions).

States were also asked to provide an estimate of the percent of drug client treatment admissions who have secondary alcohol problems. Forty-one States, the District of Columbia and Guam were able to provide information related to dual addiction problems with a result similar to that for the question posed on alcohol client admissions--widely ranging estimates (see Table 20). Again, most States estimated such dual addiction problems in the range of from 30 percent to 60 percent. Such variability indicates a need for further work on this question in the future in order to gain more valid and reliable responses from some of the States.

4. Client Admissions Data by Primary Drug of Abuse

Each State Drug (and combined Alcohol and Drug) Agency was asked to provide information on the number of client admissions by the primary drug of abuse. Forty-six States,

TABLE 19

NUMBER OF DRUG CLIENT TREATMENT ADMISSIONS BY RACE/ETHNICITY AND STATE FOR FISCAL YEAR 1989

STATE	WHITE, NOT OF HISPANIC ORIGIN	BLACK, NOT OF HISPANIC ORIGIN	HISPANIC	ASIAN OR PACIFIC ISLANDER	NATIVE AMERICAN	OTHER	NOT REPORTED	TOTAL
Alabama	3,185	1,912	N/A	N/A	N/A	12	272	5,381
Alaska	1,163	218	39	6	415	12	10	1,863
Arizona	4,721	599	1,812	36	357	0	0	7,525
Arkansas	2,227	1,348	N/A	N/A	N/A	25	N/A	3,600
California	33,520	11,094	17,444	1,315	584	0	21	63,978
Colorado	2,946	598	966	N/A	46	46	0	4,602
Connecticut	3,447	2,069	1,404	N/A	N/A	29	1,500	8,449
Delaware	797	1,029	51	N/A	N/A	N/A	N/A	1,877
District of Col	498	5,593	124	8	14	0	0	6,237
Florida	13,781	9,128	2,382	36	66	0	0	25,393
Georgia	9,950	13,992	48	13	8	32	0	24,043
Guam	3	0	0	4	0	0	0	7
Hawaii	657	43	58	925	190	58	95	2,026
Idaho	2,042	14	104	7	38	20	0	2,225
Illinois	19,188	10,856	1,657	67	65	82	256	32,171
Indiana	5,500	1,234	88	4	8	14	0	6,848
Iowa	3,967	439	59	14	54	11	92	4,636
Kansas	2,673	1,106	106	4	72	14	7	3,982
Kentucky	4,128	819	N/A	N/A	N/A	29	1,135	6,111 A
Louisiana	3,800	3,391	108	5	5	0	0	7,309
Maine	4,710	10	N/A	12	119	50	94	4,995
Maryland	8,294	9,379	N/A	N/A	N/A	161	0	17,834 B
Massachusetts	22,985	7,493	3,745	72	175	319	0	34,789
Michigan	13,831	10,001	418	26	186	82	100	24,644
Minnesota	8,149	1,512	124	19	938	55	3	10,800
Mississippi	1,982	1,796	0	0	2	0	0	3,780
Missouri	5,928	3,354	55	17	25	0	0	9,379
Montana	1,832	15	30	3	263	6	0	2,149
Nebraska	2,101	293	68	5	80	7	7	2,561
Nevada	1,612	362	133	14	3	24	0	2,148
New Hampshire	1,022	24	14	0	3	35	33	1,131
New Jersey	5,960	5,800	1,867	19	10	0	0	13,656
New Mexico	1,095	96	1,313	2	580	0	0	3,086
New York	21,006	17,798	10,394	70	89	423	36,124	85,904
North Carolina	2,944	1,943	12	N/A	97	19	4	5,019
North Dakota	576	3	2	2	63	1	3	650
Ohio	13,775	6,427	317	16	53	99	598	21,285
Oklahoma	3,323	1,170	98	4	287	0	0	4,882
Oregon	7,710	772	287	40	246	0	0	9,055
Pennsylvania	14,865	15,809	1,768	44	N/A	22	0	32,508
Puerto Rico	0	0	9,184	0	0	0	0	9,184
Rhode Island	2,790	379	147	5	12	69	1,195	4,597
South Carolina	4,337	3,615	21	3	6	0	0	7,982
South Dakota	2,719	30	0	0	971	30	0	3,750
Tennessee	5,613	1,869	13	5	6	14	2	7,522
Texas	6,505	4,462	4,052	19	49	0	6	15,093
Utah	2,559	149	279	22	48	6	21	3,084
Vermont	2,290	N/A	N/A	N/A	N/A	N/A	N/A	2,290
Virginia	10,898	7,708	223	25	31	58	452	19,395
Washington	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
West Virginia	1,468	250	1	0	0	0	0	1,719
Wisconsin	17,450	4,214	535	114	467	0	0	22,780
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTALS	318,522	172,215	61,550	3,002	6,731	1,864	42,030	605,914
PERCENT OF TOTAL	52.6%	28.4%	10.2%	.5%	1.1%	.3%	6.9%	100.0%

A = "Other" category includes "Hispanic", "Asian or Pacific Islander", and "Native American" admissions.
B = All non-White, non-Black categories are grouped in the "Other" category.

N/A = Information not available.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

TABLE 20

ESTIMATED PERCENT OF DRUG CLIENT ADMISSIONS
WHO HAVE SECONDARY ALCOHOL PROBLEMS

STATE	PERCENT	
Alabama	N/A	
Alaska	47.8	
Arizona	N/A	
Arkansas	36.0	
California	16.8	
Colorado	33.0	
Connecticut	20.1	
Delaware	53.0	
District of Col	70.0	
Florida	29.0	
Georgia	50.0	
Guam	50.0	
Hawaii	85.0	
Idaho	N/A	
Illinois	65.0	
Indiana	72.2	
Iowa	43.0	
Kansas	38.0	
Kentucky	N/A	
Louisiana	32.0	
Maine	12.0	
Maryland	21.0	
Massachusetts	46.6	
Michigan	16.0	
Minnesot	79.0	
Missis pi	31.0	
Missour	34.9	
Montana	51.0	
Nebraska	100.0	
Nevada	33.0	
New Hampshire	58.0	
New Jersey	17.0	
New Mexico	49.4	
New York	23.0	
North Carolina	N/A	
North Dakota	20.0	
Ohio	N/A	
Oklahoma	27.2	
Oregon	33.0	
Pennsylvania	100.0	
Puerto Rico	N/A	
Rhode Island	33.0	A
South Carolina	34.3	
South Dakota	N/A	
Tennessee	23.0	
Texas	24.8	
Utah	38.2	
Vermont	65.0	
Virginia	28.0	
Washington	N/A	
West Virginia	45.0	
Wisconsin	48.0	
Wyoming	N/A	

N/A = Information not available.

A = Does not include missing/unknown information.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

the District of Columbia, Guam and Puerto Rico provided at least partial data in response to this question (see Table 21). The totals indicate that, overall, cocaine treatment admissions continue to escalate ahead of heroin admissions as the primary drug of abuse. During FY 1989 cocaine treatment admissions totalled 210,869. From FY 1988 to FY 1989 cocaine admissions increased by 71,206 (34 percent) over the past year. Heroin admissions in FY 1989 numbered 124,727, up 6 percent from FY 1988. The third highest number of treatment admissions during FY 1989 by primary drug of abuse was for marijuana/hashish at 100,450 admissions. The fourth, fifth and sixth highest primary drugs of abuse related to treatment admissions were, respectively, amphetamines at 22,659 admissions, other opiates/synthetics (beyond heroin and non-treatment methadone) at 12,747 admissions and PCP at 9,241 admissions. Although the national statistics on primary drug of abuse as related to treatment admissions are as noted above, it is important to recognize that there exists tremendous variance among States as to the primary drug of abuse. For example, among the 49 jurisdictions that reported relevant data, the findings with regard to the specific primary drug of abuse, excluding the other and not reported categories, on drugs that ranked highest in each State were as follows:

- Cocaine was the primary drug of abuse related to treatment admissions within 22 States;
- Marijuana/hashish was the primary drug of abuse related to treatment admissions within 15 States and Puerto Rico;
- Heroin was the primary drug of abuse related to treatment admissions within 6 States and the District of Columbia;
- Guam reported that heroin and marijuana both ranked as the primary drug of abuse related to admissions; and
- No other single drug of abuse was ranked first among treatment admissions in any State.

A careful review of Table 21 demonstrates that different States have very different drug abuse patterns, at least as related to the primary drug of abuse for client treatment admissions.

5. Comparisons of Client Admissions Data for Fiscal Years 1985, 1986, 1987, 1988, and 1989

This subsection includes comparisons of alcohol and drug client treatment admissions data reported for FY 1989 with

TABLE 21

NUMBER OF DRUG CLIENT TREATMENT ADMISSIONS IN STATE-SUPPORTED FACILITIES BY PRIMARY DRUG OF ABUSE AND STATE FOR FISCAL YEAR 1989

STATE	HEROIN	NON-RX METHADONE	OTHER OPIATES/ SYNTHETICS	BARBITURATES	TRANQUILIZERS	OTHER SEDATIVES/ HYPNOTICS	AMPHETAMINES	COCAINE
Alabama	N/A	N/A	559	N/A	N/A	131	33	2,113 A
Alaska	125	3	49	3	9	6	23	911
Arizona	2,141	23	230	55	97	64	420	1,914
Arkansas	64	1	160	33	37	89	370	1,589
California	33,207	69	797	82	194	61	6,645	14,926
Colorado	428	18	133	5	60	14	189	1,261
Connecticut	2,968	23	100	9	15	5	24	2,808
Delaware	206	8	13	1	4	3	16	1,373
District of Col	3,802	N/A	N/A	N/A	N/A	0	N/A	1,996
Florida	1,046	0	542	78	89	98	149	17,468
Georgia	841	N/A	N/A	82	142	N/A	336	14,974
Guam	2	0	0	0	1	0	0	1
Hawaii	398	8	66	17	23	14	486	389
Idaho	42	13	31	10	15	8	176	421
Illinois	3,934	N/A	N/A	N/A	N/A	700	N/A	16,566 B
Indiana	306	N/A	305	703	N/A	N/A	701	1,540 C
Iowa	278	3	93	46	46	46	417	1,484
Kansas	N/A	N/A	244	N/A	24	48	667	1,361
Kentucky	75	25	427	105	309	186	131	1,174
Louisiana	81	3	161	36	80	53	128	3,379
Maine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maryland	5,293	49	181	28	55	23	95	5,259 D
Massachusetts	17,777	0	548	189	412	N/A	58	11,209 E
Michigan	2,505	59	521	38	152	45	264	12,369
Minnesota	297	0	439	0	0	560	947	4,227
Mississippi	18	0	126	77	27	47	52	1,645
Missouri	714	14	330	77	88	54	622	3,611
Montana	47	N/A	87	47	54	N/A	271	489
Nebraska	110	10	53	20	40	39	209	623
Nevada	329	4	23	7	7	5	234	556
New Hampshire	60	1	4	2	27	0	20	507
New Jersey	7,457	62	126	117	51	73	204	4,148
New Mexico	191	1	9	5	11	11	66	168
New York	17,984	294	315	133	303	102	188	19,529
North Carolina	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
North Dakota	N/A	N/A	20	27	N/A	N/A	42	46
Ohio	482	9	523	136	214	191	208	3,555
Oklahoma	238	8	132	60	79	60	713	1,562 F
Oregon	1,574	11	184	11	38	24	2,176	2,035
Pennsylvania	6,190	N/A	N/A	198	N/A	N/A	902	20,407 G
Puerto Rico	2,556	0	0	0	0	0	0	2,012
Rhode Island	1,167	70	119	19	78	26	26	1,208
South Carolina	662	26	136	88	166	68	86	4,101
South Dakota	5	0	24	32	42	28	161	313
Tennessee	38	5	452	32	132	169	75	2,100 H
Texas	3,378	33	223	51	79	64	1,973	6,199
Utah	420	12	160	59	66	33	192	888
Vermont	45	5	N/A	17	35	21	36	746
Virginia	2,522	97	660	117	369	214	311	7,894
Washington	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
West Virginia	13	1	138	82	133	70	44	507
Wisconsin	2,711	113	3,304	341	1,277	364	1,573	5,308
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTALS	124,727	1,081	12,747	3,275	5,080	3,817	22,659	210,869

See footnotes at bottom of next page.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

NUMBER OF DRUG CLIENT TREATMENT ADMISSIONS IN STATE-SUPPORTED FACILITIES BY PRIMARY DRUG OF ABUSE AND STATE FOR FISCAL YEAR 1989

STATE	MARIJUANA/ HASHISH	PCP	OTHER HALLUCINOGENS	INHALANTS	OVER-THE-COUNTER	OTHER	NOT REPORTED	TOTAL	
Alabama	642	N/A	24	11	N/A	1,212	656	5,381	A
Alaska	702	0	19	12	0	1	0	1,863	
Arizona	1,880	17	69	100	14	501	0	7,525	
Arkansas	1,157	0	4	27	0	69	0	3,600	
California	4,578	1,925	189	39	35	1,231	0	63,978	
Colorado	1,855	0	60	46	18	515	0	4,602	
Connecticut	936	0	40	4	0	12	1,505	8,449	
Delaware	181	34	5	1	3	21	8	1,877	
District of Col	30	390	0	0	N/A	N/A	19	6,237	
Florida	5,637	8	90	36	9	143	0	25,393	
Georgia	1,555	3,720	N/A	N/A	N/A	612	1,781	24,043	
Guam	2	0	0	1	0	0	0	7	
Hawaii	520	0	5	22	5	0	73	2,026	
Idaho	742	2	23	19	6	631	86	2,225	
Illinois	5,289	N/A	421	N/A	N/A	2,380	2,881	32,171	B
Indiana	2,594	133	363	N/A	N/A	203	0	6,848	C
Iowa	2,040	3	93	8	6	46	27	4,636	
Kansas	1,570	N/A	45	N/A	N/A	23	0	3,982	
Kentucky	2,354	14	68	48	0	0	1,195	6,111	
Louisiana	1,246	25	43	22	4	37	2,011	7,309	
Maine	N/A	N/A	N/A	N/A	N/A	N/A	4,995	4,995	
Maryland	3,534	1,466	81	57	15	1,698	0	17,834	D
Massachusetts	3,614	N/A	191	N/A	N/A	791	0	34,789	E
Michigan	4,156	30	79	44	14	3,657	711	24,644	
Minnesota	3,687	0	316	105	0	222	0	10,800	
Mississippi	692	1	36	23	8	610	418	3,780	
Missouri	3,417	186	69	66	14	117	0	9,379	
Montana	1,032	14	59	32	N/A	17	0	2,149	
Nebraska	935	0	33	30	14	445	0	2,561	
Nevada	529	8	8	4	1	8	425	2,148	
New Hampshire	415	1	21	0	0	36	37	1,131	
New Jersey	883	80	53	7	14	381	0	13,656	
New Mexico	591	4	11	44	6	401	1,567	3,086	
New York	6,419	158	151	21	57	38,022	2,228	85,904	
North Carolina	N/A	N/A	N/A	N/A	N/A	N/A	5,019	5,019	
North Dakota	416	N/A	1	N/A	N/A	98	N/A	650	
Ohio	3,566	11	70	94	72	199	11,955	21,285	
Oklahoma	1,055	45	26	121	11	669	103	4,882	F
Oregon	2,614	9	64	15	4	296	0	9,055	
Pennsylvania	3,676	N/A	N/A	N/A	N/A	1,135	0	32,508	G
Puerto Rico	3,329	0	0	48	0	810	429	9,184	H
Rhode Island	593	5	67	10	14	0	1,195	4,597	
South Carolina	1,960	1	40	79	27	175	367	7,982	
South Dakota	782	5	23	75	0	2,250	10	3,750	
Tennessee	1,308	3	30	55	4	2,650	469	7,522	I
Texas	2,675	2	71	259	7	33	46	15,093	
Utah	938	5	42	92	9	66	102	3,084	
Vermont	756	N/A	48	3	23	112	443	2,290	
Virginia	4,209	582	291	136	59	1,934	0	19,395	
Washington	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
West Virginia	554	13	29	73	13	49	0	1,719	
Wisconsin	6,605	341	616	113	113	0	1	22,780	
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
TOTALS	100,450	9,241	4,087	2,002	599	64,518	40,762	605,914	

A = Alabama's "Other" drug category includes mixed or polydrug abuse where a single primary drug of abuse is not specified.

B = Illinois' "Heroin" drug category includes all narcotics, the "Other Sedatives/Hypnotics" category includes all sedatives and hypnotics, and the "Other Hallucinogens" category includes all hallucinogens.

C = Indiana's "Barbiturates" drug category includes tranquilizers and the "Other" category includes inhalants.

D = Maryland's "Other" drug category includes 1,364 clients with primary alcohol problems and 313 collaterals with no alcohol or drug abuse problems themselves.

E = Massachusetts' "Other Sedatives and Hypnotics" category includes Barbiturates, and "Other Hallucinogens" category includes PCP.

F = Oklahoma's "Other" drug category includes alcohol.

G = Pennsylvania's "Heroin" category is primarily heroin users but includes some "Non-Rx Methodone" users and some "Other Opiates and Synthetics" users.

H = Tennessee's "Other" drug category includes 2,573 drug treatment admisions where alcohol is the primary drug of abuse.

N/A = Information not available.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

that reported for FY 1985, FY 1986, FY 1987 and FY 1988. This material is organized under two topic headings as follows:

- o Comparisons of alcohol client admissions data; and
- o Comparisons of drug client admissions data.

Information on each of these areas is presented within the following paragraphs. Data analyses are included in this subsection only for those States that provided data for all five fiscal years.

a. Comparisons of Alcohol Client Admissions Data

For those State Agencies that provided alcohol client admissions information for FYs 1985, 1986, 1987, 1988 and 1989 a number of data comparisons were conducted. Forty-six States, the District of Columbia and Puerto Rico were able to provide information for all five years. The total alcohol client treatment admissions for these State Agencies rose from 1,095,341 in FY 1985 to 1,157,404 in FY 1986 and to 1,251,946 in FY 1987 before dropping to 1,209,975 in FY 1988 and to 1,209,691 in FY 1989. Overall, during the five year period from FY 1985 through FY 1989 alcohol treatment admissions increased by 114,350 or 10.4 percent. However, there exists considerable variability in both overall admissions levels and types of admissions across individual States.

Among the 48 States and Territories that provided data for all five years, admissions were down between FY 1985 and FY 1989 for 21 reporting entities, while admissions were up for 27 reporting entities. Also, among some of the States that reported major increases in alcohol client admissions from FY 1985 to FY 1989, the changes may be related as much to the utilization of more comprehensive and complete reporting systems as to actual increases in the numbers of clients admitted to services. Therefore, considerable caution should be exercised in the interpretation of these data.

b. Comparisons of Drug Client Admissions Data

A number of comparisons were conducted on data provided by those State Agencies that submitted drug client admissions information for FYs 1985, 1986, 1987, 1988 and 1989. Most of these analyses were similar to the alcohol client comparisons. Forty-four States, the District of Columbia and Puerto Rico were able to provide some relevant information for all four years. The total drug client admissions figures for these State Agencies rose from 301,283 in FY 1985 to 370,887 in FY

1986 to 433,839 in FY 1987 to 511,484 in FY 1988 and to 590,383 in FY 1989 (an increase of 289,100 admissions or nearly 96 percent during this five-year period). However, these data reveal considerable variability across States in terms of increases and/or decreases in drug client admissions. The overall trend of significant increases in the number of drug client admissions is confirmed by the fact that most of the States and Territories that have comparable drug client treatment admissions data reported an increase in admissions. However, a number of the States have begun to utilize more comprehensive reporting systems. Therefore, considerable caution should be exercised in the interpretation of these data, since it is likely that the increased levels of drug admissions reported by States may be related not only to increased numbers of actual drug clients being admitted to treatment, but also to more complete reporting now possible through more comprehensive and complete data systems (e.g., the addition in a few States of drug clients served through the community mental health center service system whose client admissions were not reported in earlier years).

Another comparison of drug client treatment admissions over FYs 1985, 1986, 1987, 1988 and 1989 focused on the primary drugs of abuse. An analysis was conducted on roughly comparable data provided by 44 States, the District of Columbia, and Puerto Rico on the top three primary drugs of abuse (i.e., heroin, cocaine and marijuana/ hashish). The findings were as follows:

CLIENT TREATMENT ADMISSIONS
BY TOP THREE PRIMARY DRUGS OF ABUSE

FISCAL YEAR	Heroin	Cocaine	Marijuana/ Hashish
1985	87,834	38,903	58,616
1986	83,931	56,445	70,003
1987	95,433	82,232	59,001
1988	116,589	138,739	78,825
1989	124,186	208,515	97,867

It is clear that the above data exhibit considerable variation from year to year and caution must be exercised in attempting to extract trend data. However, the increases in client treatment admissions related to cocaine as a primary drug of

abuse are particularly clear and compelling. The data demonstrate an increase of 17,542 admissions or 45.1 percent from FY 1985 to FY 1986, an increase of 25,787 admissions or 45.7 percent from FY 1986 to FY 1987, an increase of 56,507 admissions or 68.7 percent from FY 1987 to FY 1988 and an increase of 69,776 admissions or 50.3 percent from FY 1988 to FY 1989. Client treatment admissions with cocaine specified as the primary drug of abuse from FY 1985 to FY 1989 increased by 169,612 admissions or nearly 436 percent. Over that same five-year period client admissions related to heroin increased by 41.4 percent, while admissions related to marijuana/hashish increased by nearly 67 percent.

V. INTRAVENOUS (IV) DRUG ABUSE (Table 22)

Each State Alcohol and Drug Agency was asked to provide estimates relating to IV drug abuse for Fiscal Year (FY) 1989 for the total number of client admissions to treatment and the total number of IV drug abusers in the State. With regard to the number of admissions of IV drug abusers to State-funded and non-State-funded programs the State Agencies were asked to indicate the basis for their estimate (i.e., "individual client data" and/or informed "guesstimate"). Agencies within a total of 48 States, the District of Columbia, Guam and Puerto Rico were able to provide an estimate for at least one of the two questions (See Table 22).

There were responses from 50 jurisdictions to the question on the total number of treatment client admissions to State-funded programs during FY 1989 who were reported to be IV drug abusers. The number of IV drug abuser client treatment admissions ranged from a high of 35,297 in California to a low of 26 in North Dakota and 2 in Guam. The total number of IV drug abuser client treatment admissions to State-funded-programs reported by the 50 respondents for FY 1989 was 186,805.

With regard to a question on the total number of IV drug abuser treatment client admissions to non-State-funded programs during FY 1989, responses were received from 21 States and Puerto Rico. The number of such admissions in States ranged from a high of 36,388 in California to a low of 24 in Arkansas. The total number of IV drug abuser treatment client admissions to non-State funded programs reported for FY 1989 was 61,096. The combined total of IV drug abuser treatment client admissions to both State-funded programs and non-State-funded programs for FY 1989 was 247,901.

Thirty-eight (38) States, the District of Columbia, Guam and Puerto Rico were able to provide estimates on the total number of IV drug abusers in the State. The highest estimates of IV drug abusers were provided by New York, California and Texas, in that order. New York estimated 260,000, California estimated 222,000 and Texas estimated 188,000 IV drug abusers in the State. The total number of IV drug abusers across the country as estimated by the 41 State Agency respondents is 1,482,347.

TABLE 22

ESTIMATES OF INTRAVENOUS (IV) DRUG ABUSER CLIENT TREATMENT ADMISSIONS TO STATE FUNDED AND NON-STATE FUNDED PROGRAMS AND ESTIMATES OF TOTAL IV DRUG ABUSERS BY STATE FOR FISCAL YEAR 1989

STATE	NUMBER OF ADMISSIONS IN STATE FUNDED PROGRAMS WHO WERE IV DRUG ABUSERS	BASIS OF ESTIMATE	NUMBER OF ADMISSIONS IN NON-STATE FUNDED PROGRAMS WHO WERE IV DRUG ABUSERS	BASIS OF ESTIMATE	ESTIMATED TOTAL NUMBER IV DRUG ABUSERS IN STATE
Alabama	500	G	40	G	N/A
Alaska	584	G/IND	288	G	4,410
Arizona	2,648	G	N/A		5,313
Arkansas	783	IND	24	G	7,830
California	35,297	IND	36,388	IND	222,000 A
Colorado	2,431	IND	N/A		12,000
Connecticut	4,866	G/IND	N/A		35,000
Delaware	1,358	G	N/A		13,000
District of Col	2,804	G	N/A		16,000
Florida	11,911	G	3,522	G	67,192
Georgia	5,000	G/IND	N/A		N/A
Guam	2	IND	N/A		200
Hawaii	593	IND	N/A		1,200
Idaho	759	IND	N/A		2,896
Illinois	5,986	IND	645 B	IND	100,000
Indiana	2,863	G	5,135	G	28,220
Iowa	1,389	IND	1,000	G	14,883
Kansas	1,829	IND	2,341	IND	N/A
Kentucky	853	IND	N/A		5,000
Louisiana	3,100	IND	N/A		N/A
Maine	3,379	IND C	N/A	N/A	950
Maryland	7,741	IND	1,739	IND	45,000
Massachusetts	13,001	IND	2,000	G	40,000
Michigan	3,100	IND	N/A		50,000
Minnesota	1,300	IND	1,300	IND	4,500
Mississippi	N/A	G	N/A		N/A
Missouri	3,781	IND	N/A		22,000
Montana	963	IND	N/A		2,500
Nebraska	223	G	N/A		800
Nevada	700	G	400	G	5,000
New Hampshire	242	IND	630	G	9,000
New Jersey	5,782	IND	316	IND	40,000
New Mexico	672	G	N/A		N/A
New York	14,875	IND	2,600	IND	260,000
North Carolina	2,000	G	N/A		N/A
North Dakota	26	G	26	G	100
Ohio	4,000	IND	N/A		N/A
Oklahoma	1,900	G	800	G	14,000
Oregon	2,622	IND	N/A		26,220 D
Pennsylvania	9,731	IND	N/A		88,000
Puerto Rico	2,707	IND	1,054	IND	5,093
Rhode Island	2,016	G	N/A		10,080
South Carolina	1,500	G	N/A		N/A
South Dakota	183	IND	47	IND	1,530
Tennessee	1,688	IND	676	G	N/A
Texas	7,858	IND	N/A		188,000
Utah	671	G/IND	N/A		N/A
Vermont	700	IND	N/A		3,900 E
Virginia	1,933	G/IND	N/A		19,330
Washington	N/A		N/A		25,000
West Virginia	176	G	N/A		200
Wisconsin	5,779	G	125	G	21,000
Wyoming	N/A		N/A		N/A
TOTALS	186,805		61,096		1,482,347

A = California's 36,388 IV drug abuse admissions into non-State funded programs represent methadone clients only.
B = Non-State funded admissions figures represent non-hospital based services only.
C = Based on information obtained from new client information system recently implemented for FY 1989.
C = Information does not include drug detox clients.
D = Figures based on admit data collected on over 40% of client admits.

N/A = Information not available.

G = Guesstimate of number of admissions who were IV drug abusers.
IND = Individual client data were used to determine numbers of admissions who were IV drug abusers.

Source: State Alcohol and Drug Abuse Profile, FY 1989; data are included for "only those programs which received a least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989."

VI. STATE MODEL PRODUCT AVAILABILITY

In order to identify current model product availability within each State, the State Alcohol and Drug Abuse Agency representatives were asked to list products that would be of interest to other States and that could possibly either be replicated or used by other State agencies. A total of 43 State Agency representatives responded to this question. See Appendix C for a summary of the State-by-State data provided.

The majority of the product categories reported by the States included: treatment plans/models; prevention plans/models; materials on AIDS/HIV; program certification/licensure/ accreditation standards; counselor certification/ licensing and training standards; needs assessments and surveys; and State planning and administrative documents. Other materials mentioned by the State Agency representatives ranged from reports on special populations such as the hearing impaired and elderly to DWI screening, drug free workplace policies and the program monitoring process.

Twenty-one States reported at least one treatment program plan or model product. The model treatment services included programs for youth, women, the elderly and types of services, i.e., residential, halfway house and outpatient care. Services for the homeless and for chronic addicts were also mentioned.

Seventeen State Agencies reported the availability of prevention oriented programming and planning materials. A total of 40 specific prevention products were reported, the majority of which are youth oriented. Other materials mentioned range from community-based efforts to information for parents. Four States reported on school programs such as Student Assistance Programs and curricula.

A total of 16 State Agencies reported at least one product on HIV/AIDS. The products range from State policies on AIDS, and HIV/AIDS transmission prevention programs, to AIDS knowledge studies.

Eleven State Agencies identified at least one product relating to counselor certification/licensing standards. Also, 11 State Agencies provided information on program certification/licensing/ accreditation standards.

Products that address alcohol and other drug dependent pregnant women and women with children were mentioned by 11 States. They include how-to manuals for implementing and operating specialized programs for this population, need assessments, model programs and information related to continuum of treatment for pregnant and post partum women.

Needs assessments and surveys were reported by 4 State Agencies. The assessments included statewide prevention and treatment needs; surveys also addressed student alcohol and other drug abuse.

Fourteen States reported product availability categorized as "Special" for purposes of this report. Products for the hearing impaired; drug free workplace policies and programs; homeless projects; programs for public inebriates; and teen pregnancy prevention and parenting programs were all mentioned.

State planning documents, administrative rules and legislative reports and documents were reported by 12 State Agencies. A total of 25 products were reported to be available for use by other State Agencies.

VII. TOP THREE POLICY ISSUES FROM A STATE ALCOHOL AND DRUG AGENCY PERSPECTIVE (Table 23)

In order to identify the policy questions and issues that are currently being considered at the State level, the State Alcohol and Drug Agency representatives were asked to list their top three policy issues. Forty-nine States, the District of Columbia, Guam, and Puerto Rico responded to this question (see Table 23 for a summary of the State-by-State responses).

In compiling the results from the responses to this question it was determined that five policy areas were mentioned by at least 16 State Agencies. These lead policy issues can be categorized as follows:

- Treatment Services Systems;
- Services to Special Populations, including Persons with HIV and AIDS;
- Administration and Staffing;
- Funding and Resource Allocations; and
- Prevention and Treatment Services for Youth;

A further analysis of each of these five issue areas follows:

1. Treatment Services Systems

Forty-seven State Agencies identified the need for additional services or expansion of existing treatment services as a major policy issue. Expansion of service systems to reduce waiting lists and to increase services was mentioned by respondents from 32 State Agencies. Specific mention was made by seven States of the need to ensure and enhance availability of quality treatment services. These State Agencies included Arizona, Illinois, Iowa, Kansas, Michigan, Montana, and New York. Other related issues identified by State Agencies included the need to strengthen continuum of care services, integration of alcohol and drug treatment services with other social and health services, and the need for service evaluation.

2. Services to Special Populations, Including Persons with HIV and AIDS

Twenty-eight State Agencies specifically identified the need to expand prevention and treatment services to underserved special populations, including HIV and AIDS, women, dually diagnosed,

TABLE 23

TOP THREE POLICY ISSUES BY STATE ALCOHOL AND DRUG AGENCIES

STATE			
ALABAMA	1. INTEGRATION OF TREATMT. & PREV. SERV.	2. OUTCOME EVALUATION	3. EXPANSION OF STATE FUNDING SUPPORT
ALASKA	1. BROADEN PROGRAM SERVICES FINANCING	2. MEDICAID REIMBURSEMENT FOR SERVICES	3. PREVENTION/TREATMENT BALANCE
ARIZONA	1. RESIDENTIAL FAC. FOR YOUTH	2. STABLE TREATMENT FUNDING	3. CREATE/ENHANCE FACILITIES
ARKANSAS	1. COMPREHENSIVE ADOLESCENT TREATMENT	2. SERVICES FOR MINORITIES/WOMEN	3. SERVICES FOR DUALLY DIAGNOSED
CALIFORNIA A	1. LICENSING & CERTIFICATION OF PROGRAMS	2. COORD. OF FED/STATE/LOCAL/PRIVATE SVCS.	3. DEVELOPMENT OF VARIETY OF SERVICES
CALIFORNIA D	1. IV DRUG USERS/AIDS VICTIMS	2. PERINATAL DRUG EXPOSURE	3. ADOLESCENT TREATMENT
COLORADO	1. SERVICES FOR CHILD/TEENS/FAMILY	2. MORE SVCS FOR THOSE WHO CREATE VICTIMS	3. NEEDS ASSESSMENTS AT COMMUNITY LEVEL
CONNECTICUT	1. STATEWIDE REGIONAL PLANNING MODEL	2. PLANNING & STRATEGIZING SOLUTIONS	3. CRIMINAL JUSTICE CLIENTS
DELAWARE	1. IV DRUG USERS INFECTED BY AIDS VIRUS	2. DEVELOP APPROPRIATE A/D SERVICES	3. INCREASING DEMAND FOR O/P RES/DETOX SERVICES
DIST. OF COL.	1. PRENATAL CARE/ADDICTION TREATMENT	2. EXPAND DUAL DIAGNOSED INDIGENT/YOUTH SVCS.	3. EXPANSION OF ANCILLARY DRUG SERVICES
FLORDIA	1. INCREASE SA TREATMENT FOR WOMEN	2. EXPAND TREATMENT SVCS FOR HIGH RISK	3. EXPAND PREV/INTERVEN. SVCS FOR HIGH RISK
GEORGIA	1. SERVICES FOR PREGNANT WOMAN	2. LONG TERM SERVICES FOR COCAINE/CRACK	3. ADOLESCENT SERVICES CONTINUUM
GUAM	1. URINALYSIS DRUG TESTING CAPABILITIES	2. RESIDENTIAL TREATMENT OF D/A CLIENTS	3. DETOX FACILITY FOR A/D CLIENTS
HAWAII	1. COMPREHENSIVE SYSTEM OF SERVICES	2. COORD. OF PLANNING/DATA COLLECTION	3. ACCRED/CERTIF. OF SA COUNSELORS
IDAHO	1. UPGRADE A/D LICENSURE STANDARDS	2. LICENSURE FOR ADOLESCENT A/D PROGRAM	3. MANDATORY CERTIF. FOR A/D PROVIDERS
ILLINOIS	1. LONG-TERM PREV./TREATMENT FUNDING	2. RESOURCES FOR EXPANDING SERVICES SYSTEM	3. IMPROVE QUALITY OF CARE
INDIANA	1. NEGATIVE IMPACT OF FEDERAL PRIORITIES	2. 3RD PARTY REIMBURSEMENT FOR TREATMENT	3. COORDINATION OF PREVENTION INITIATIVES
IOWA	1. IMPROVE SERVICES	2. EXPAND SERVICES, ESPECIALLY JUVENILE	3. PREGNANT WOMEN
KANSAS	1. TREATMENT FOR INDIGENT YOUTH	2. UPGRADE INDIGENT ADULT TREATMENT SVCS.	3. COUNSELOR CREDENTIALING

TABLE 23

TOP THREE POLICY ISSUES BY STATE ALCOHOL AND DRUG AGENCIES

STATE			
KENTUCKY	1. MEDICAID REIMBURSEMENT	2. TRMT. FOR DUI AND DRUG OFFENDERS	3. ASSESSMENT/TREATMENT FOR PRISONERS
LOUISIANA	1. MEDICAL REIMBURSEMENT	2. COORDINATING OF HOSPITAL/COMMUNITY DETOX	3. CONTRACTING WITH PRIV. FACILITIES
MAINE	1. ORGANIZE STATE GOVT.SUB.ABUSE SVCS.	2. DRUNK DRIVERS EVALUATION/TREATMT. SVCS.	3. FOSTER PRIVATE WORKSITE SA PROGRAMS
MARYLAND	1. AIDS CRISIS RELATED TO SUBSTANCE ABUSE	2. DEVELOP OF ASSESSMENT/PLACEMENT/EVAL.	3. EXPANSION & EVALUATION OF PREV. SERVICES
MASSACHUSETTS	1. AIDS HIV INFECTION ACCESS TO TRMT.	2. ALCOHOL & DRUG-FREE HOUSING	3. SERVICES FOR PREGNANT WOMEN
MICHIGAN	1. DRUG TESTING	2. SANCTIONS FOR YOUTHFUL DRUG OFFENDERS	3. N/A
MINNESOTA	1. ADEQUATE TREATMENT FOR LOW INCOME	2. ADEQUATE FUNDING FOR DETOX	3. DAYCARE FOR WOMEN & FAMILIES WITH DEPENDENT
MISSISSIPPI	1. DRUG TESTING	2. SANCTIONS FOR YOUTHFUL DRUG OFFENDERS	3. N/A
MISSOURI	1. ZONING/CNTY. ACCEPTANCE TREAT PROG.	2. QUALIFIED TREATMENT PERSONNEL	3. COMMUNITY DEVELOPMENT/PARTICIPATION
MONTANA	1. MAINTAIN QUALITY SERVICES	2. EXPAND COMMUNITY BASED TREATMENT SVCS.	3. ALLOCATING FED./ST. FUNDS FOR QUALITY SVCS
NEBRASKA	1. FUNDING LEVEL AND DISTRIBUTION	2. EVALUATION OF TREATMENT	3. COUNSELOR CERTIFICATION
NEVADA	1. EXPANDING TREATMENT/PREVENTION SVCS.	2. CHILDREN OF ADDICTED MOTHERS	3. CHANGING PUBLIC AWARENESS & ATTITUDES
NEW HAMPSHIRE	1. MAINTAIN FUNDING FOR PREV./TREATMENT	2. EFFICIENCY OF TRMT. & PREVENTION EFFORTS	3. BLOCK GRANT REQUIRE. IMPACT ON SMALL STATES
NEW JERSEY	1. MANDATORY DRUG TREATMENT REIMBURSE.	2. MEDICAID REIMBURSEMENT FOR ALCO. TRTMENT	3. FUNDS & SITING FOR DRUG TREATMENT FACILITIES
NEW MEXICO	1. COMPREHENSIVE STATEWIDE SA SVCS PLAN	2. PROGRAM OUTCOME & IMPACT EVALUATION	3. DRUG CONTROL STRATEGY
NEW YORK A	1. INCREASE AVAILABILITY OF SERVICES	2. INCREASE SERVICES FOR UNDERSERVED	3. RECRUITMENT OF QUALIFIED COUNSELORS
NEW YORK D	1. RESPONDING TO AIDS & HOMELESSNESS	2. IMPROVE THE QUALITY OF EXISTING SERVICES	3. EXPAND NETWORK OF SERVICES ACROSS THE STATES
NORTH CAROLINA	1. FUNDING ACCOUNTABILITY	2. DEVELOPMENT OF CLIENT CENTERED SERV. SYS.	3. ORGANIZATION OF SA SVC DELIVERY & MANAGE.
NORTH DAKOTA	1. FUNDING AND RESOURCE ALLOCATION	2. TREATMENT SERVICES TO SPECIAL POPULATIONS	3. PREVENTION SERVICES - FUNDING & EXPANSION
OHIO	1. SOCIAL INOCULATION OF YOUTH AGAINST SA	2. PROVISION OF CARE OF SPECIAL POPULATION	3. MAINTAIN NEW DEPT. OF A/D ADDICTION SERVICES

TABLE 23

TOP THREE POLICY ISSUES BY STATE ALCOHOL AND DRUG AGENCIES

STATE			
OKLAHOMA	1. DEVELOP. OF M/H CENTERS AS O/P NETWORK	2. SPECIAL TREATMENT FOR PREGNANT WOMEN	3. N/A
OREGON	1. TREATMENT CAPACITY	2. MAINTAINING SOBORITY UPON TREATMENT	3. INITIATION OF ADD'L PREVENTION STRATEGIES
PENNSYLVANIA	1. ADDICTED PREGNANT WOMEN/WITH CHILDREN	2. CASE MANAGEMENT SERVICES	3. SERVICES TO SPECIAL POPULATIONS
PUERTO RICO	1. PRIVATE COVERAGE FOR A/D DETOX/TRTMT.	2. POLICY FOR METH. PATIENTS WHO USE DRUG	3. OBTAINING COMMUNITY COOPERATION
RHODE ISLAND	1. MAINTAIN PREVENTION/TREATMENT SVCS.	2. SERVICES FOR UNDERSERVED POPULATIONS	3. MAINTAINING/EXPANDING AIDS-RELATED SERVICES
SOUTH CAROLINA	1. CONSOLIDATE MANAGE, OF STATE SYSTEM	2. FOCUS ON ALCOHOL AS MAJOR DRUG OF ABUSE	3. IMPACT OF ALCOHOL/DRUGS ON MINORITIES
SOUTH DAKOTA	1. NEED FOR ADOLESCENT TRANSITIONAL FAC.	2. ADULT CUSTODIAL CARE FACILITIES	3. PREV. PROG. TO ADDRESS SPECIFIC RISK FACTORS
TENNESSEE	1. REORGANIZATION OF SVCS. DELIVERY SYS.	2. EXPANSION OF TREATMENT/PREV. FUNDING	3. INCIDENCE AND PREVALENCE STUDY
TEXAS	1. ADD'L SERVICES FOR CHILDREN & YOUTH	2. SERVICES FOR MEDICALLY INDIGENT ADULTS	3. SERVICES FOR IV USERS & AT RISK YOUTH
UTAH	1. ESTABLISHING STATEWIDE FUND. FORMULA	2. PLANNING FOR INFLUX OF NEW FED. FUNDS	3. COORDINATION OF ALCOHOL & OTHER DRUG SERVS.
VERMONT	1. AIDS PREVENTION AND INTERVENTION	2. SPECIAL POP. NOT ACCESSING TX RESOURCES	3. TRTMT. EFFICACY DEMONSTRATION/STUDY NEEDED
VIRGINIA	1. SERVICES TO SPECIAL POPULATIONS	2. MEDICAID INDIGENT HEALTH CARE	3. AIDS AND I.V. DRUG ABUSE
WASHINGTON	1. ESTABLISHING MGMT INFORMATION SYSTEM	2. APPROPRIATE TREATMENT PREGNANT WOMEN	3. CONTINUUM OF TRTMT SVCS. FOR POOR/HOMELESS
WEST VIRGINIA	1. CUSTODY OF JUV. ARRESTED FOR INTOX.	2. TREATMENT OF DUALLY DIAGNOSED M/H	3. CERTIFICATION OF SUB. ABUSER FOR MEDICAID
WISCONSIN	1. DEVELOPMENT OF A STATEWIDE ALLIANCE	2. DEVELOPMENT OF POLICY TO REDUCE COCAINE	3. ESTABLISH STRATEGY FOR UNDERSERVED NEEDS
WYOMING	1. N/A	2. N/A	3. N/A

homeless, and criminal justice clients. Eleven State Agencies, including Arkansas, the District of Columbia, Florida, Georgia, Iowa, Massachusetts, Minnesota, Michigan, Oklahoma, Pennsylvania and Washington, highlighted the need for additional services for women, including pregnant women. Nine States, representing a broad geographic distribution of States, identified AIDS and IV drug abuse as a major policy issue. These States, included California, Delaware, Maryland, Massachusetts, New York, Rhode Island, Texas, Vermont and Virginia. Five State Agencies, Kansas, Minnesota, Texas, Virginia and Washington, mentioned the need to meet the treatment needs of the indigent. Improving treatment services to the dually diagnosed was addressed by three State agencies, including Arkansas, the District of Columbia and West Virginia.

3. Administration and Staffing

Twenty-seven State Agencies identified a variety of administrative and staffing issues as policy priorities, including coordination of Federal, State, local and private services; certification and credentialling of programs and staff; organization and reorganization of service delivery systems; and enhancement of community support for prevention and treatment. The need for enhanced coordination was identified as a major policy issue by nine States: California, Connecticut, Hawaii, Indiana, Louisiana, New Mexico, North Carolina, Utah and Wisconsin. Seven States, California, Hawaii, Idaho, Kansas, Missouri, Nebraska and New York, mentioned the need for qualified staff and/or the need for licensure and certification standards. The need for organization/reorganization of State service delivery systems was noted by six States: Maine, North Carolina, Ohio, South Carolina, Tennessee and Washington. Four State Agencies, including Missouri, Nevada, New Jersey and Puerto Rico identified community acceptance and locating acceptable program sites as policy priorities.

4. Funding and Resource Allocation

Eighteen State Agency representatives identified the need to seek increased funding for treatment and prevention services and/or to improve the allocation of resources as at least one or more of their top three policy issues. Twelve State Agency respondents mentioned in general terms the need to develop funding policies for maintaining existing services or to expand services to meet increasing needs. Those States included: Alabama, Arizona, Illinois, Michigan, Minnesota, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Tennessee and Utah. Eight State and Territorial Agencies addressed the need to expand alcohol and other drug treatment coverage under third party reimbursement programs including private health insurance, Medicare and Medicaid. These agencies included Alaska, Indiana, Kentucky, Louisiana, New Jersey, Puerto Rico, Texas and Virginia.

5. Prevention and Treatment Services for Youth

The expansion of prevention and treatment services for youth was identified as a major policy issue by 17 State Agencies including: Alabama, Alaska, California, District of Columbia, Florida, Georgia, Indiana, Iowa, Maryland, Nevada, New Hampshire, North Dakota, Ohio, Oregon, Rhode Island, South Dakota, and Texas. Specific policy issues ranged from treatment modalities for youth, funding for adolescent programs, services for indigent youth, integration of treatment and prevention services, to overall prevention services for youth.

VIII. MAJOR NEEDS FOR WHICH RESOURCES WERE NOT ADEQUATE IN FISCAL YEAR 1989

Each State Alcohol and Drug Abuse Agency was asked to indicate whether there were any major needs identified through the State's most recent planning process for which there were inadequate resources to meet those needs. The State representatives were asked to provide a brief description of those major needs and to identify the types of resources that would be required. Detailed State-by-State information on the major needs and resources identified is included as Appendix D.

Responses to this question were received from 49 State Agencies, the District of Columbia, Guam and Puerto Rico. All of the respondents indicated that major needs existed in their service delivery systems for which resources were not adequate during FY 1989.

Narrative responses received from the 52 State and Territorial Agencies confirmed that there are major needs in the areas of prevention and/or treatment for which there are not adequate resources. While the scope of the narrative comments and information retrieved was broad, many of the respondents stated that additional resources need to be obtained to support the development and maintenance of a variety of treatment and prevention services, particularly for youth and women. In addition, States identified the following needs: to provide services to meet the needs of other special populations such as the homeless, elderly, dually diagnosed, persons living with HIV infection and/or AIDS and the incarcerated; to expand facilities for detoxification and residential treatment; to increase funding for program staff positions, training and salaries; to expand services to improve prevention in both schools and communities; and to upgrade and/or remodel facilities.

The major need most frequently mentioned in the FY 1985, FY 1986, FY 1987, FY 1988 and the current FY 1989 SADAP effort was the development of prevention and treatment services for youth and women. For FY 1989 a number of States reported specific needs for additional residential beds as well as needs for an increase in staff positions and child care services in women's programs. All of the reporting States mentioned that additional overall funding would aid in reconciling the distance between needs and the existing service levels. Some States reported that the "Not in my backyard" attitude in communities was hampering efforts to establish treatment units. In addition, several States mentioned the special needs and problems of pregnant, addicted mothers and of babies born as addicts.

Other service needs that were identified by some States included the following: expansion of publicly funded treatment units; long-term care for chronic alcoholics; outreach and outpatient services, particularly in rural areas; additional treatment "slots" to reduce the backlog of clients on waiting lists for treatment; and particular problems which complicate the recovery process such as the mentally ill and the need to upgrade treatment facilities to meet State standards.

Highlights from the States' narrative reports have been organized into the following categories:

- Youth and Women;
- Other Special Populations;
- Staff Positions, Training and Salaries; and
- Prevention and Early Intervention; and
- "Special" State Needs: Site Renovation, Remodeling and Locations; and Assistance in Data Collection.

1. Youth and Women

The majority of the reporting States identified a need to expand treatment and prevention/intervention services to youth (34 States). While many States indicated a variety of needs in the areas of prevention and treatment for alcohol- and drug-abusing youth, 20 State Agency representatives specifically mentioned the expansion or establishment of residential and outpatient programs for youth. Several of these States are: Arizona, California, Idaho, Kentucky, Maryland, South Carolina and Tennessee. Several States referred to youth needs in general terms such as: "adolescent services." Some of these States include: Alabama, Alaska, Indiana, Nebraska and Pennsylvania.

Both Kansas and Montana reported a problem with providing services to indigent youth. Kentucky cited the need for transitional care for chemically dependent adolescents. South Carolina has targeted programs and services for adolescents as the top treatment priority citing a need for an adolescent inpatient treatment facility, halfway house, nine intensive outpatient programs and additional adolescent counseling specialists. West Virginia noted a particular need for additional residential treatment units for adolescents to facilitate family involvement and aftercare.

Twenty-two States, up from fifteen in FY 1988, reported a need for resources for services for women. Some of these States are: California, Florida, Illinois, Minnesota, New Hampshire and

Wisconsin. The need for child services was also noted. Prenatal care and parenting skills training were also reported as significant needs by California and New Jersey. This continues a pattern from the FY 1988 report when Florida, Pennsylvania and Washington indicated child care services were needed for women in treatment.

2. Other Special Populations

State Agency representatives from 26 States indicated treatment and prevention service needs for special populations. They reported requirements for special programs for the elderly, homeless, hearing impaired, AIDS patients, chronic alcoholics, disabled, Vietnam Veterans, correctional clients and individuals who are addicted and mentally ill (dually diagnosed). Connecticut and Ohio mentioned specific service needs for the elderly. Services for homeless and/or chronic alcoholics were reported by Alaska, Connecticut, Illinois, Minnesota, New Jersey, New York, North Carolina, Puerto Rico and Tennessee. Treatment and rehabilitation services for AIDS patients were indicated by New York, North Dakota, Puerto Rico and Wisconsin. Oregon and Wisconsin specifically reported needs for the hearing and visually impaired. California, Minnesota, Oregon and South Dakota mentioned special needs of ethnic minorities and the problems related to language barriers in providing adequate treatment services. Services for dually diagnosed clients were mentioned as important needs by Arkansas, Illinois, Louisiana, New Hampshire, North Dakota, Oklahoma, Oregon, Rhode Island, Tennessee, Washington and Wisconsin. Indiana, New York and Oregon indicated a need for treatment services targeted to clients in the criminal justice system.

3. Staff Positions, Training and Salaries

Nineteen responding State Agencies identified a need to provide or expand staff training. The need to increase the number of program staff positions and the level of staff salaries was also cited.

Respondents from two State Agencies, Illinois and Washington reported a need for staff training for the dually diagnosed, i.e., substance abusers and mentally ill clients in treatment. Also, four State Agencies, Alabama, California, Kansas and Ohio, cited a need for appropriately trained staff to provide necessary services to chemically dependent adolescents.

Additional staff training was cited as an important need by the State Agencies in the District of Columbia, Guam, Hawaii, Massachusetts, Michigan, Mississippi New York (alcohol), North Carolina, North Dakota, Oklahoma, Texas, Vermont and West Virginia.

Additional resources to adequately compensate workers in the substance abuse field was stated as a significant need by Arizona, Florida, Iowa, Michigan and New Hampshire. However, a number of other States made reference to the need for increases in salaries in more general terms.

4. Prevention and Early Intervention

Additional resources for prevention and early intervention services for the general population, including members of special populations, were identified by respondents from the following 13 State Agencies: Alaska, Arkansas, California, Connecticut, Kansas, Kentucky, Maine, Missouri, Montana, Nebraska, Ohio, Oregon and Utah. Alaska's representative again indicated a need for prevention services to establish an inhalant prevention program. Kansas and Kentucky reported a major need for the completion of a regionalized prevention programming. Connecticut cited its recently established "Governor's Interagency Plan on Youth Substance Abuse Prevention and Intervention" which identified many prevention "needs" particularly in the areas of AIDS, addicted babies and special populations.

California's State representative indicated a need to strengthen existing recovery and prevention programs for targeted high-risk groups. Maine is searching for effective ways to link treatment and prevention services to other human service systems and, likewise, Montana cited the need for expansion of prevention efforts to include increased cooperation between service agencies within the communities and at the State level. Insufficient resources have left Missouri's school system with a waiting list to receive prevention programming.

5. "Special" State Needs: Site Renovation, Remodeling, and Location; and Assistance in Data Collection

Eleven State Agency respondents reported a need to renovate or remodel aging alcohol and drug abuse treatment units or to locate sites for new treatment facilities. Adequate resources are needed to respond to the former two needs. However, community and/or neighborhood resistance to locating treatment facilities has hampered the expansion of needed units in Maryland and New York.

Other "Special" State needs centered on data collection capabilities, computer hardware and technical assistance to upgrade data collection systems. Colorado specifically mentioned the need for a reporting and data collection system for addicted infants. South Carolina indicated that information and data processing technology at the local level is in urgent need of improvement.

IX. SIGNIFICANT CHANGES IN ALCOHOL AND OTHER DRUG PREVENTION AND TREATMENT SERVICES IN FISCAL YEAR 1989

Each State Alcohol and Drug Abuse Agency was requested to provide information on changes that had occurred in treatment and/or prevention services during Fiscal Year (FY) 1989. A total of 50 responses were received to this question, representing 47 States, the District of Columbia, Guam and Puerto Rico. The specific narrative information obtained from each respondent is contained in Appendix E.

The narrative comments provided by the State Agency representatives addressed a broad range of significant topics and functions. However, there were sufficient commonalities in the State responses to cluster their replies into the following seven categories:

- o New Programs and Services for AIDS and IV Drug User Populations;
- o Client and Drug Use Trends;
- o Changes in Financial Resources;
- o Changes in Services and Programs for Youth;
- o Prevention Programs and Services;
- o Changes in Admissions to Treatment; and
- o Other Significant Developments.

Information from the States has been reviewed and is summarized according to the foregoing categories. An analysis of the data provided within each of these seven categories follows.

1. New Programs and Services for AIDS and IV Drug User Populations

Sixteen State Agencies provided narrative comments related to the availability of services to IV drug users to help prevent the spread of the HIV infection and AIDS. Those State Agencies include: Alaska, California, Colorado, Connecticut, District of Columbia, Florida, Illinois, Louisiana, Missouri, New York (alcohol and drug), Ohio, Oklahoma, Vermont, Virginia and Wisconsin.

The majority of States reported an increased emphasis in services for AIDS and IV drug users in order to address the escalating number of such persons entering the alcohol and other

drug abuse treatement system. Several States (Alaska, Colorado, Connecticut, New York, Wisconsin) also cited the development and implementation of HIV/AIDS training programs.

The State of Connecticut reported continued expansion in the area of AIDS education, testing and counseling programs in treatment sites, staff training on AIDS issues, and AIDS Risk Reduction Outreach Worker programs. Increased education and outreach efforts were also reported by Florida, Louisiana and Vermont.

The State of Ohio employed the services of an AIDS consultant who is in the process of coordinating requirements related to HIV pre and post test counseling, partner notification, mantoux testing and outreach for HIV counselors housed in methadone clinics in the State. Virginia developed a staff position to specialize in AIDS and enhance community awareness on HIV and AIDS issues.

Other comments by State Agencies included the following:

- o Colorado - Have developed new AIDS regulations and associated training programs.
- o Louisiana - The Division of Alcohol and Drug Abuse has joined with the Office of Public Health to fund community-based positions to provide AIDS education and counseling to persons in need in the alcohol and drug abuse system.
- o New York - The Division has been providing training to local program staff to prepare them to respond appropriately as the prevalence of AIDS and HIV-infection among alcohol patients increases. The treatment of persons with AIDS will require additional program resources to provide patient education and special support services.

2. Client and Drug Use Trends

Several States reported a rise in the use of cocaine, particularly in the form of "crack" as evidenced by an increase in treatment admissions and infants born addicted to the substance.

These States included Alabama, Georgia, Massachusetts, Michigan, Mississippi, Missouri, Texas and Vermont. Some of these States have found it necessary to effect changes in services in order to meet new demands being placed on the treatment system.

While reporting a decline in overall drug abuse that began in the last quarter of 1988, the District of Columbia also noted that cocaine remains the drug of choice among illicit drug users. The District of Columbia also reported a 57 percent increase over 1988 in juvenile drug related arrests. Also, Alabama, Kansas and Kentucky reported that the population being served is decreasing in age.

Other States that mentioned drug use and client trends included:

- o Arizona - Growth in drug abuse clients treated in FY 89, as well as overall increases in ethnic populations served.
- o Hawaii - Growing use of crystal methamphetamine began to impact regional perinatal centers, mental health treatment programs and substance abuse treatment programs.
- o Missouri - Cocaine use, especially crack, has exploded from 164 cases in FY 83 to 3,570 in FY 89. In FY 89, cocaine became the second most commonly abused drug after alcohol in Missouri.
- o Vermont - Number of cocaine abusers in treatment increased by 95 percent from FY 87 to FY 89.

3. Changes in Financial Resources

Narrative comments by representatives from 15 State Agencies referred to specific financial changes during the last fiscal year, 1989. Several of these remarks were directly related to increased funding provided by State legislatures. Examples of States receiving mandated support to develop or expand services included the following:

- o California - The State enacted legislation in 1989 to support expansion of services to the repeat DUI offender.

- Connecticut - The State Agency reported the enactment of legislation to provide funding for expansion of substance abuse treatment.

- North Dakota - Legislation within the State mandated a reduction in hospital admissions, but made funding available to regional human services centers in order to provide services located more conveniently to clients' homes.

- Texas - The State legislature appropriated additional funds for services for children and youth.

In addition to State mandated funding, some States reported the use of Federal monies to increase treatment services generally and to target specific populations. Those States included the following:

- Colorado - The State Agency reported receiving new program funding through new direct grant programs from the Office for Substance Abuse Prevention (OSAP).

- Hawaii - The State Corrections Department received a Federal grant for substance abuse treatment planning for the prison population.

- New Jersey - 1989 ADMS Block Grant monies were used by the State to expand and implement specialized services for indigent women, particularly pregnant women.

- Pennsylvania - Act 152 of 1988 enabled State Medicaid funds to be available for residential non-hospital treatment services for the first time.

As has been the case in the past, the States are operating under distinct conditions with an assortment of financial situations. While some States have been able to improve services with new and/or increased levels of funding, others have found it necessary to reallocate resources, while still others find themselves contending with reduced funding.

4. Changes in Services and Programs for Youth

Youth services received specific mention by representatives from a number of State Agencies in FY 1989. Increase in the provision of prevention and treatment services for youth was the most frequently mentioned change.

Specific program initiatives by the States included:

- o Arizona - Major shift to early intervention programs for high risk youth.
- o New Mexico - Increase in services to adolescents due to a better identification and referral system and expansion of services to this population.
- o Oregon - Prevention/intervention and adolescent treatment services are now available in every county in the State.
- o Utah - Treatment services to youth have increased 46 percent between FY 1988 and FY 1989, due to the increased focus of State and local funding priorities.

5. Prevention Programs and Services

In addition to the previously discussed prevention services directed toward youth, a number of State Agencies identified prevention programs in general as a significant area of change during FY 1989.

Some examples of States' prevention activities included:

- o California - The Department undertook a major reorganization which included the prevention

function. This reorganization was to combine the alcohol and other drug prevention and program development activities into a single branch.

- o Indiana - Establishment of the "Commission for a Drug Free Indiana" -- to expand efforts of developing a more integrated approach to prevention services.

- o North Dakota - Efforts are progressing in developing a network of prevention programs and people throughout the State. The first Statewide Prevention Conference was held in 1989; training of trainers for two parenting in prevention programs will occur in early 1990; and a new quarterly newsletter are all early efforts at facilitating some grassroots networking for alcohol and other drug abuse prevention activities.

6. Changes in Admissions to Treatment

Several State Agencies emphasized changes in alcohol and other drug admissions. The reasons for the admission changes differ from State to State. Some examples of State Agency reports included the following:

- o Alabama - Providers report a rise in crack/cocaine addicted admissions and a decline in age of population served, particularly in half-way houses.

- o Colorado - Developments include new offender residential treatment services, TASC programs for parolees, pre-release programs and changes in the corrections diagnostic center to improve detection of substance abuse problems.

- o Guam - With the discontinuance of the methadone treatment program within the Department of Mental Health and Substance Abuse several years ago, there has been a significant decrease in the number of clients seen in drug treatment services.

- o Delaware - In order to counteract the shortage of residential treatment slots and the gaps in the overall system's continuity of care, the State Agency is developing a network of intensive outpatient, case management and continuous treatment teams to address the needs of the chronic and high-risk substance abusing populations.

- o Kansas - While there has been a decrease in admissions of persons with alcohol problems, there has been an increase in admissions for other drug problems. Overall, admissions are increasing.

- o Massachusetts - Admissions for cocaine treatment continue to increase.

- o Nevada - In FY 1989 the Bureau began funding a transitional program for women which allows women's children to stay with them in the program.

7. <u>Other Significant Developments</u>

Increased emphasis on specialized services to women, changes in Driving While Intoxicated (DWI) and Driving Under the Influence (DUI) legislation and increased cooperative planning were included by State Agencies among new developments. Some specific examples follow:

- o California - The Alcohol Programs Division added a pilot program for women who are pregnant or post partum and their children.

- o Maryland - Outreach and other services to pregnant substance abusers and other special populations were increased.

- o New Jersey - 1989 ADMS Block Grant Award monies allocated for specialized services for women, especially pregnant women, were used to expand and implement services for the following critical needs: (1) case finding in perinatal centers; (2) educating health professionals about Fetal Alcohol Syndrome (FAS); (3) purchase of 28 day residential stays from licensed facilities; and (4) implementation of halfway house and shelter services for women with dependent children.

Changes in DWI and DUI legislation within States were mentioned by several State agencies, including the following:

- o California - Legislation enacted in 1989 provided for the expansion of services provided to the repeat DUI offender. Legislation was also enacted to mandate State licensure of first-offender drinking driver programs.

- o Mississippi - Because of increased penalties for DUI convictions, treatment programs have modified their outpatient treatment services.

- o Montana - DUI legislation requires all second and subsequent offenders to be admitted to treatment. In addition, only certified counselors are allowed to conduct client assessments.

- o Vermont - The State passed legislation requiring mandatory treatment screening for all DWI offenders.

Some States reported increased cooperative planning and programming efforts at the State and local levels.

Examples of cooperative endeavors included the following:

- California - The Department of Alcohol and Drug Programs, in collaboration with the Departments of Health Services and Social Services, is currently implementing a three-year pilot project to provide prenatal health care, alcohol recovery and drug treatment services, social services and other supportive services to pregnant and parenting women and their children.

- Louisiana - The Division of Alcohol and Drug Abuse has joined with the Office of Public Health to fund community-based positions to provide AIDS education and counseling to persons in need in the alcohol and drug abuse system.

- North Dakota - The creation of the Policy and Planning Commission for Alcohol and Other Drug Abuse Prevention will, among other things, ensure the development of a comprehensive plan to coordinate efforts, reduce duplication, and fill in gaps in programs and services. The Commission consists of State Prevention Agency staff, State legislators and State Executive Branch staff and citizens.

X. RESPONSES TO SPECIAL QUESTIONS

The 1989 SADAP posed four special questions all relating to issues that are currently of major concern within the alcohol and other drug abuse field. Specifically, the State Alcohol and Drug Abuse Agencies were asked to respond to questions centering on issues and concerns relating to measurement of access to appropriate care; prevention and treatment program needs; problems in accessing care for alcohol and drug dependent pregnant women; and, finally, information on children born to alcohol and other drug dependent women.

Following are brief analyses of State responses to each question.

1. Issues and Concerns Relating to Measurement of Access to Appropriate Care/Waiting Lists/Continuum of Care Services

For years alcohol and other drug treatment providers have been reporting a critical lack of capacity within the publicly funded treatment system. Often individuals seeking treatment have been unable to obtain services immediately and some have been placed on waiting lists, many of which exceed two weeks wait. These waiting lists are one indication of the severe problem being faced by the nation -- many individuals are seeking treatment but are not receiving appropriate care in a timely manner. In an effort to collect some objective information in this area the FY 1989 SADAP for the first time asked the State Alcohol and Drug Agencies to describe their issues and concerns relating to measurement of access to appropriate care/waiting lists/continuum of care services.

Forty-nine State Agencies provided narrative comments in response to the request (see Appendix F). It is clear from the responses that States interpreted this new data request in at least two different ways. First, many States provided statements that raised concerns about the accuracy of waiting lists as a measurement of whether appropriate care and continuum of care services are being provided. Second, some States, based on their narrative comments, seemed to interpret the request as a three fold question, i.e., information was being sought on measurement of access to appropriate care, measurement of waiting lists and measurement of access to continuum of care services. Given that this request was posed for the first time, different interpretations by the States are not surprising. It is anticipated that in the future this subject matter may be further expanded upon and thus more consistent responses are expected.

Overall, the majority of responses indicated a very real concern among States in the use of waiting lists as an assessment of whether the needs of persons seeking treatment are being met.

Many States questioned the validity of waiting lists given that some treatment programs do not maintain formalized lists and that many times a client unable to access one program is either referred to another program or will himself seek alternate treatment services and is therefore placed on "multiple" waiting lists. In addition, some States cited waiting lists as providing an incomplete picture of unmet needs for services. For example, even though someone has an alcohol/drug problem and wants help, if (s)he knows that being given help means (s)he will simply be placed on a waiting list, many individuals become discouraged and will not seek the help they need.

The following brief analysis of State responses has been organized into three sections:

- Measurement of Access to Appropriate Care;
- Waiting Lists; and
- Continuum of Care Services.

A. Measurement of Access to Appropriate Care

Some States responded that they have a number of concerns about determining clients' ability to access appropriate services to meet their needs. These concerns center in particular around lack of current data collection capability and inconsistent definitions of service and need categories.

The District of Columbia cited a need for: case management personnel; coordination of existing services; increased aftercare services and enhanced data collection capability, as major issues for the continuum of care and access to services. Idaho indicated that a lack of data has left the State unable to determine who has attempted to access treatment and has not received it. North Carolina cited a need for improved methodology and data on service utilization in order to conduct more effective planning.

In Kentucky, the definition of outpatient capacity Statewide is a problem. The State of Maine has found that obtaining a complete picture has been complicated by the use of different definitions by different service providers.

In addition, Massachusetts suggested that appropriate care requires standards that match clients to services and measures of achievement to assess outcomes. In New York, the Alcohol Program Division has a "need" methodology that indicates how much of what type of service is needed and then evaluates the actual availability of services against the need.

B. Waiting Lists

Thirty States addressed the issue of waiting lists and as noted earlier, most raised concerns about the use of such lists as an accurate measure of need. However, some States did raise other issues related to waiting lists.

The California Department of Alcohol and Drug Programs is participating in the federal Drug Abuse Treatment Waiting List Reduction Grant Program that will provide helpful data to the State, while Delaware is closely monitoring waiting lists at all treatment agencies to assess shifts, trends, etc. Also, Missouri suggested that lawmakers be educated about the strengths and weaknesses of using waiting lists as a measure of demand for treatment.

C. Continuum of Care Services

Only a few States provided narrative responses addressing issues related to continuum of care services. Alaska's unique situation as a primarily rural State with many communities accessible only by air has created serious problems in matching clients with appropriate treatment and has provided "unusual" problems in the provision of family and aftercare services. Hawaii is missing components of continuum of care services, particularly on the neighbor islands. Illinois' problem of large gaps in the treatment system, both in its ability to serve additional clients and its capacity to provide continuum of care services necessary to meet needs, has served to inappropriately decrease lengths of stay for some clients while creating intermittent treatment cycles for others.

2. Problems Experienced by Pregnant Women in Accessing Care for Alcohol and/or Other Drug Problems

Public concern with regard to the number of women with alcohol and other drug abuse problems has grown in recent years. Similarly, there has been an increase in public concern related to the number of substance abusing pregnant women and those with children. This special population requires unique, specialized services that address a variety of essential needs. In order to identify the obstacles met by this population in obtaining treatment, the State Alcohol and Drug Agencies were asked to identify the problems encountered in accessing care for pregnant women who seek treatment for alcohol and/or other drug problems in the State.

In assembling the results from the States' responses (see Appendix G) it is clear that while States are experiencing a wide range of problems in accessing care for pregnant women, three major

problems were consistently mentioned by at least 15 States. The three major problems are organized as follows:

- o Lack of Trained Staff and Specialized Facilities;
- o Lack of Child Care Services for Women in Treatment; and
- o Emergence of Legal Implications.

Further analysis of each of these areas follows.

A. Lack of Trained Staff and Specialized Facilities

The needs of alcohol and other drug abusing pregnant women and those with children are extensive and complex. Many States noted a critical need for counselors who have received specialized training in providing outreach, as well as treatment services for pregnant addicted women. In addition, specialized treatment facilities that provide appropriate services for pregnant women and their children are not available in many if not most States. As with other populations, long waiting lists are a result where appropriate programs do exist. Twenty-two State Agencies (Alaska, Arizona, California, Colorado, District of Columbia, Georgia, Hawaii, Kansas, Kentucky, Maine, Massachusetts, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Oklahoma, Oregon, Tennessee, Texas, Virginia, West Virginia) identified a shortage of both specially trained staff and specialized facilities to address the treatment needs of alcohol and drug dependent pregnant women as a major obstacle in accessing care for this special population. One means of addressing this shortage would be to develop better coordination between the primary health care system and the alcohol and other drug abuse treatment system. As noted by at least eight States, a lack of such coordination has resulted in many instances in an inability of staff to provide intervention and continuity of care in meeting the various essential needs of pregnant women and their children.

B. Lack of Child Care Services for Women in Treatment

Nineteen State Alcohol and Drug Agencies indicated that treatment programs within the State lacked provisions for child care or acceptable child care alternatives while women are in treatment. Without any practical options to provide for the care of their other children, pregnant women are reluctant to enter treatment. The nineteen State Agencies that specifically indicated lack of child care services within treatment programs for pregnant women were: Alabama, Alaska,

Arizona, California, Connecticut, Delaware, Florida, Georgia, Maine, Massachusetts, Minnesota, Missouri, Montana, New Hampshire, Rhode Island, Utah, Virginia, Washington and West Virginia.

C. Emergence of Legal Implications

The advent within some States in recent years of new laws that impose punishments for child abuse/neglect against addicted pregnant women has produced a new and greater problem in the identification and treatment of pregnant women with alcohol and other drug problems. Because of fear of retribution (including loss of custody of other children), some of these women tend to avoid seeking needed services, particularly since in some cases the providers of these services may be required by law to report the abuse. In addition, many treatment programs are reluctant to treat pregnant women because of limited or no medical support to ensure appropriate pre-natal services, particularly for high risk pregnancies and because of concern for liability issues. The fifteen States that mentioned legal implications as a problem in treating pregnant addicted clients include: Colorado, District of Columbia, Florida, Georgia, Kansas, Michigan, Minnesota, Mississippi, Missouri, New York, Oklahoma, Rhode Island, South Carolina, Texas and Wisconsin.

3. State Needs for Additional Program Staff

This year for the first time a question was included within the FY 1989 SADAP asking the State Agencies to provide information on the number of "additional program staff of all types (that) are currently needed in your State's publicly funded: treatment system?------ prevention system?------". Treatment system program staff estimates were provided by a total of 37 jurisdictions, including 34 States, the District of Columbia, Guam and Puerto Rico. They ranged widely across respondents from a low of 3 in one Territory to a high of 3,000 in one State. Across all 37 jurisdictions treatment staff needs were estimated to total 13,262 persons. However, due to the fact that some large State Agencies (i.e., California, Michigan, New York Drug Agency, Ohio and Texas) did not provide estimates of treatment staff needs, these data must be interpreted cautiously as providing only minimal estimates.

Prevention system program staff estimates were provided by a total of 38 jurisdictions, including 36 State Agencies, the District of Columbia and Guam. They also ranged widely across respondents from a low of 0 in one State to a high of 321 in another. Across all 38 jurisdictions prevention staff needs were estimated to total 2,806 persons. However, as noted above for the treatment staff need projections due to the fact that a number of

large State Agencies did not provide estimates, these data must be interpreted cautiously as providing only minimal estimates of needs.

Finally, due to the variability in the estimates provided by different States, as well as to the non-respondent problems noted above, the data provided should be viewed primarily as a starting point to design and conduct a more in-depth study of the treatment and prevention staffing needs as perceived by the State Agencies.

4. Information on Alcohol and Other Drug Exposed Babies

The increase in recent years in women of child bearing age who are dependent upon alcohol and/or other drugs has created a new and disturbing phenomena -- babies born addicted. As a prelude to a possible future, more in-depth study of this issue (e.g., the development of a SADAP Special Report), States were asked to provide any relevant information they had available on children born to women who use alcohol and/or other drugs during pregnancy.

Eighteen States provided varied information on this issue (see Appendix H-1) ranging from the titles of documents that cover the problem, to the results of surveys and research studies conducted within the States, to special projects and related activities.

Delaware, Hawaii, Minnesota, Nevada, Tennessee and Virginia made reference to surveys or research studies conducted within the State related to babies born addicted to alcohol and/or other drugs. The Medical Center of Delaware reports 6,000 deliveries at the facility each year and notes that 10 per cent of delivering mothers test positive for some drug. In Hawaii the majority of substance using pregnant women are not being identified. The State Agency reports that a retrospective study conducted by one hospital of delivery records showed fewer than 100 women identified over the last two and one half years. However, the State Agency predicts that 11 percent of Hawaii's annual births could result in over 2,000 drug-affected infants each year and nearly 100 infants annually requiring special services because of maternal alcohol use.

California, Massachusetts, Michigan, New York (Drug Agency) and Texas submitted the names of publications/documents that address issues and/or provide relevant information related to identification, prevention, trends and/or estimates of maternal alcohol and/or other drug use and its impact on newborns.

APPENDIX A

STATE ALCOHOL AND DRUG ABUSE PROFILE COVER LETTER, INFORMATION COLLECTION FORMAT AND GLOSSARY OF TERMS

NASADAD

National Association of State Alcohol and Drug Abuse Directors

October 30, 1989

President
John S. Gustafson
New York

First Vice President
Lou Olson
Missouri

Vice President for Alcohol Abuse Issues
Paul Behnke
Arkansas

Vice President for Drug Abuse Issues
Linda Lewis
Florida

Past President
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Wayne Thacker
Virginia
Michael Townsend
Kentucky
Joan Walker
Michigan
Bob Dickson
Texas
Andrew O'Donovan
Kansas
Robert Aukerman
Colorado
Ed Zborower
Arizona
Matthew Felix
Alaska

Executive Director
William Butynski

Matthew Felix, Coordinator
Office of Alcoholism and Drug Abuse
AK Department of Health & Social Services
Pouch H-05-F
Juneau, AK 99811

Dear Mr. Felix:

I am writing to request your continued participation in the National Association's information collection activities. Two years ago we entered into a new three year contract with the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) to continue operation of the State Alcohol and Drug Abuse Profile (SADAP).

Since 1982 the State and Territorial Directors have unanimously expressed their willingness to participate in a NASADAD voluntary data collection effort. Forty-eight States, the District of Columbia, Guam, Puerto Rico and the Virgin Islands participated in the 1988 SADAP. The information collected on alcohol and drug abuse services through SADAP is of considerable value and interest to the States, the Federal Government and the U.S. Congress, all of whom increasingly recognize the need for ongoing data collection.

The attached form, which I ask that you complete and submit to the NASADAD office by December 5, 1989, is the result of many hours of effort by a State consultant group made up of your peers and staff that met earlier this month. The format for the 1989 SADAP has been updated but maintains the key elements from prior years. One change this year is some progress toward consistency with the proposed minimum data set distributed to you by NIAAA and NIDA several months ago. What had been separate type of care and environment matrices for alcohol and drug client admissions, have finally been combined into one question. If you have

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questions on the change, don't hesitate to call NASADAD staff who can help you to ensure that your data is presented accurately.

Responses to the attached form should be gathered from secondary information sources already existing at the State level. As in previous years, a report displaying the information collected through the SADAP effort on a national and State-by-State basis will be made available to you once it is completed. Also, in recognition of the substantial contribution that you and your staff make to SADAP, we will include both your name and that of your data persons in the final SADAP report.

Although the SADAP format has been designed to be simple and straightforward, a few brief instructions may assist your staff in completing the form. First, an updated glossary of terms has been included to assist in resolving any questions regarding definitions. The glossary of terms should be reviewed by your staff before responding to the questions on the SADAP form. Second, most questions request information only on those programs that receive at least some funds administered by the State Alcohol/Drug Agency. For those programs, please provide information on all alcohol and drug resources and clients in such programs, not just the services or clients which are supported by State Alcohol/Drug Agency administered funds. Third, this year we are again requesting information on actual expenditures of funds. However, if you cannot provide actual expenditures in the timeframe given, please note this fact and provide your most recent allocation figures.

Finally, I urge you to give special attention to the two questions which request a narrative response on service needs and significant changes in alcohol and/or drug services (questions 18 and 19). In the past, information derived from the States' responses to these questions has proven invaluable to NASADAD and the Federal Government in demonstrating to the Congress and the Administration the major needs of the States. If you have any questions or require clarification on any of the requested items, please do not hesitate to contact Chris Heldman, Diane Canova, or Bill Butynski of the NASADAD staff.

On behalf of the NASADAD Board of Directors and myself, I thank you for ongoing cooperation and participation in our information collection efforts.

Sincerely,

John S. Gustafson

John S. Gustafson
President

Enclosures

NASADAD
STATE ALCOHOL AND DRUG ABUSE PROFILE FOR FY 1989

State:_____ State Contact:_____ Telephone: ( )_____

Please complete and return this form by December 5, 1989 to: NASADAD, 444 North Capitol Street, N.W., Suite 520, Washington, D.C. 20001. REFER TO GLOSSARY OF TERMS FOR APPROPRIATE DEFINITIONS.

I. FUNDING INFORMATION

1. Report the total dollar expenditures for alcohol and drug abuse services by source o funding and type of activity for ONLY THOSE PROGRAMS which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (FY) 1989 (NOTE: All boxes must be filled in with: (1) a dollar amount; (2) a zero "0" denoting that no funds from that funding source are expended for the particular activity; or (3) an "N/A" indicating that the information is not available.)

Funding Source	Type of Activity			
	Treatment	Prevention	Other*	TOTAL
A. A&D Block Grants				
B. Other Federal				
C. State A/D Agency				
D. Other State				
E. County or Local				
F. Other Sources				
G. TOTAL				

*Includes State Alcohol/Drug Agency costs for administration, evaluation, research, training, and other non-treatment and non-prevention categories).

2. Indicate the number of alcohol and/or drug treatment units which received funds administered by the State Alcohol/Drug Agency in FY 1989:

   A. combined alcohol/drug treatment units _____.

   B. alcohol only treatment units _____.

   C. drug only treatment units _____.

3. Of all known alcohol and/or drug abuse treatment units in the State in FY 1989, regardless of funding source, estimate the percent that received any funds administered by the State Alcohol/Drug Agency: _____.

II. ALCOHOL/DRUG CLIENT INFORMATION

NOTE: All information in this section is to be based on primary alcohol and/or drug problem client admissions to those treatment units (reported in item 2 above) which received some funds administered by the State Alcohol/Drug Agency during the State's FY 1989.

A. ALCOHOL/DRUG CLIENT ADMISSIONS

4. Enter the number of Alcohol and/or Other Drug client admissions for each of the following categories during FY 1989:

	ALCOHOL	OTHER DRUG	TOTAL
Detoxification, 24 Hour/Day Care			
hospital inpatient			
free-standing residential			
Rehabilitation/Residential			
hospital (other than detoxification)			
short-term (30 days or less)			
long-term (over 30 days)			
Ambulatory			
outpatient			
methadone			
detoxification (non-methadone)			
TOTAL			

Note: See the last part of the Glossary for definitions for the above categories and for information on how to fit data organized according to the prior year separate alcohol and drug matrices into this one combined matrix.

B. ALCOHOL CLIENT ADMISSIONS

5. Enter the number of ALCOHOL treatment client admissions during FY 1989 in each of the age, sex and race/ethnicity categories below. If unable to provide data on age by sex, provide totals for age and sex categories.

a

SEX / AGE	NO. OF CLIENTS MALE	FEMALE	TOTAL
UNDER 18 YRS.			
18 - 20			
21 - 24			
25 - 34			
35 - 44			
45 - 54			
55 - 64			
65 and over			
Missing/Unknown Information			
TOTAL			

b

CLIENT RACE/ETHNICITY	NO. OF CLIENTS
White, not of Hispanic Origin	
Black, not of Hispanic Origin	
Hispanic	
Asian or Pacific Islander	
Native American	
Other	
Missing/Unknown Information	
TOTAL	

(NOTE: Grand totals for ALCOHOL admissions in Questions 4, 5a and 5b should agree.)

6. How many of the primary ALCOHOL problem treatment client admissions have secondary Other DRUG problems? _____ percent.

III. DRUG CLIENT ADMISSIONS

7. For the total Other DRUG treatment client admissions noted in item 4 above, enter th number of client admissions in each of the primary drug of abuse categories below:

Heroin	_____	Other Sedatives and Hypnotics	_____	Other Hallucinogens	_____
Non-RX Methadone	_____	Amphetamines	_____	Inhalants	_____
Other Opiates and Synthetics	_____	Cocaine	_____	Over-the-Counter	_____
Tranquilizers	_____	PCP	_____	Missing/ Unknown	_____
				TOTAL	_____

8. Enter the number of Other DRUG treatment client admissions during FY 1989 in each c the age, sex and race/ethnicity categories below. If unable to provide data on age by sex, provide totals by age and sex categories.

a

SEX / AGE	NO. OF CLIENTS MALE	FEMALE	TOTAL
UNDER 18 YRS.			
18 - 20			
21 - 24			
25 - 34			
35 - 44			
45 - 54			
55 - 64			
65 and over			
Missing/Unknown Information			
TOTAL			

b

CLIENT RACE/ETHNICITY	NO. OF CLIENTS
White, not of Hispanic Origin	
Black, not of Hispanic Origin	
Hispanic	
Asian or Pacific Islander	
Native American	
Other	
Missing/Unknown Information	
TOTAL	

(NOTE: Grand totals for Other Drug admissions in Questions 4; 7. 8a and 8b should agree.)

9. How many of the primary Other DRUG problem treatment client admissions have seco ALCOHOL problems? _____ percent.

IV. OTHER INFORMATION

10. Intravenous (IV) Drug Abuse

A. Enter the total number of treatment client admissions in State funded program during FY 1989 who were IV drug abusers: _____. Please indicate whether this number is based on: client data ____ or is a guesstimate _____.

B. Enter the total number of treatment client admissions in non-State funded programs during FY 1989 who were IV drug abusers: _____. Please indicate whether this number is based on: client data _____ or is a guesstimate _____.

C. Estimate the total number of IV drug abusers in your State: _____. Please indicate the method used to derive the estimate:

_____

_____

_____

D. Do you have any information on Human Immunodeficiency Virus (HIV) infection rates among IV drug abusers in your State? ____ Yes ____ No. If "Yes" please append any available relevant data to this form.

11. Please list products currently available in your State that would be of interest and could possibly be replicated or used in other States, e.g., AIDS policies, counselor and/or program certification/licensing standards, criminal justice interface services descriptions of innovative or model programs, drug-free workplace policies, drug/testing plans, Medicaid reimbursement, model prevention and/or treatment plans, need assessment survey methodologies, new legislation, program monitoring systems or evaluation reports, resource allocation methodologies. After each product title include name of contact person.

A. _____

B. _____

C. _____

12. What is the status of Medicaid reimbursement for alcohol and other drug services in your State (check one):

☐ Medicaid currently reimburses the cost of some alcohol and/or other drug treatment services

☐ Medicaid currently does not reimburse for alcohol and/or other drug services, but we are currently exploring/seeking such reimbursement

☐ Medicaid currently does not reimburse for alcohol and/or other drug services, and we are not seeking such reimbursement

13. Describe your issues and concerns relating to measurement of access to appropriate care/waiting lists/continuum of care services.

_____

_____

_____

_____

14. What are the problems in accessing care for pregnant women who seek treatment for alcohol and/or other drug problems in your State? Please discuss.

_____

_____

_____

_____

15. How many additional program staff of all types are <u>currently</u> needed in your State's publicly funded:

treatment system? _____

prevention system? _____

16. If you have relevant information on children born to women who use alcohol and/or other drugs during pregnancy please append it.

17. Please identify your State Agency's top three policy issues:

A. _____

B. _____

C. _____

18. Please provide a brief narrative description of major needs for which resources are not adequate and the types of resources required (e.g., facilities, funds, services for special populations, staff, technology, training, etc.).

19. Briefly describe any significant changes in alcohol and/or drug prevention and treatment services delivered within your State in FY 1989 and the reasons for these changes (e.g., adolescent services; AIDS; criminal justice services; impact of funding changes; increase or decrease in use of cocaine, methamphetamine/ice or other drugs; increased intoxicated driver enforcement efforts; numbers of substance exposed infants; voluntary group activities; and/or changes in drug abuse trends).

SADAP - 1989
Glossary of Terms

A&D Block Grants - Federal funds awarded to the State via the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant program, including the Part C, Emergency Alcohol and Drug Treatment and Rehabilitation (ADTR) Funds, and used to support the provision of alcohol and/or drug treatment or prevention services.

Amphetamines Admissions - Individuals admitted for all types of amphetamine problems, including methamphetamine use as well as other types of amphetamines such as pills.

Client Admissions - Individuals admitted to and provided services in appropriate treatment settings according to State definitions.

Cocaine Admissions - Individuals admitted for all types of cocaine problems, including crack, free-base and/or intravenous use of cocaine; in future years route of administration of cocaine may be requested.

County of Local Monies - Funds that are provided by county or local governments to support the provision of alcohol and/or drug treatment or prevention services.

Hospital - An institution that provides 24-hour services for the diagnosis and treatment of patients through an organized medical or professional staff and permanent facilities that include inpatient beds, medical and nursing services. Client admissions should be counted if they are receiving detoxification or treatment services primarily for alcoholism and/or other drug abuse.

Native American - The race/ethnicity group including Alaskan Natives, American Indians and Native Hawaiians.

Other (Type of Activity) - Other activities beyond treatment or prevention services, e.g., training, research and administration. All State Agencies have some administration costs and these should be shown in this category.

Other Federal - All Federal funds used for support of alcohol and/or drug treatment or prevention services other than the A&D Block Grant monies. These could include funds provided through Federal programs sucha s the Social Services Block Grant, Medicare, the Federal share of Medicaid, Veterans Administration, Indian Health Service, Department of Education, and Department of Justice.

Other Sources - All funds used for support of alcohol and/or drug treatment or prevention services other than monies from the A&D Block Grant program, Other Federal, State A/D Agency, Other State, County or Local sources. These funds could include reimbursement from private health insurance, client fees, court fines or assessments for treatment imposed on intoxicated drivers.

Other State - State revenues appropriated to State governmental units or programs other than the State Alcohol and/or Drug Agency which are used to support alcohol and/or drug treatment or prevention services. These funds may or may not eventually be administered by the State Alcohol and/or Drug Agency. These funds would include the State share of Medicaid funds provided for treatment services unless the Medicaid share is provided by the State Alcohol and/or Drug Agency's State appropriation.

Outreach - Activities with objectives to increase the level of awareness of an agency's services in the community and among specific professionals to form linkages with referral, support and aftercare services. These activities may be in the form of public education, training, promotions, participation in coordination bodies, and other activities.

Prevention - Those activities that are designed to prevent individuals and groups from becoming dependent on the regular use of alcohol and/or licit or illicit drugs. Available services may vary widely but are generally associated with information, education, alternatives, and primary and early intervention activities, and may also encompass services such as literature distribution, media campaigns, clearinghouse activities, speaker's bureau, and school or peer group situations. These services may be directed at any segment of the population. When reporting allocation of A&D Block Grant funds, early intervention services may be included within this category.

State A/D Agency Funds - State revenues, earmarked taxes or seized assets specifically appropriated to the State Alcohol and/or Drug Agency for support of alcohol and/or drug treatment, prevention or other related services.

Treatment - A broad range of formal organized services (including diagnostic assessment, detoxification, counseling, medical, psychiatric, psychological, social service, vocational services, outreach and aftercare support) for persons who have abused alcohol and/or other drugs. These services are designed to alter specific physical, mental or social functions of persons under treatment by reducing client disability or discomfort, ameliorating the signs or symptoms caused by alcohol and/or drug abuse and influencing the behavior of such individuals in a positive way toward identified objectives/goals and improved functioning.

Treatment Unit - Discrete location, building or stand alone facility where alcohol and/or drug treatment services are provided by specially trained staff. In the case of outreach services, count only the permanent base of operations.

Vocational Services - Structures and consistent activities with an ultimate expectation of full or partial employment, including, but not limited to: job readiness training, vocational training, on-the-job training, apprenticeships, employment services, job search services. These services are not to be confused with formal academic or school activities.

DEFINITIONS FOR QUESTION 4.
FOR ALCOHOL/DRUG CLIENT ADMISSIONS INFORMATION

Detoxification, 24 Hour/Day Care

Hospital inpatient - 24 hour/day medical acute care services for detoxification for persons with severe medical complications associated with withdrawal

Free-standing residential - 24 hour/day services in non hospital setting providing for safe withdrawal and transition to ongoing treatment.

Rehabilitation/Residential

Hospital (other than detoxification) - 24 hour/day medical care in an acute care hospital facility in conjunction with treatment services for alcohol and other drug abuse and dependency

Short-term residential (30 days or less) - typically 30 days or less of non acute care in a setting with treatment services for alcohol and other drug abuse and dependency

Long-term residential (over 30 days) - typically over 30 days of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency; this may include transitional living arrangements such as halfway houses.

Ambulatory

Outpatient - ambulatory treatment services including individual, family and or group services; these may include day treatment, intensive outpatient treatment, or pharmacological therapies other than methadone

Methadone - outpatient treatment services in conjunction with prescribed methadone (include methadone detoxification and maintenance)

Detoxification (non-methadone)	-	outpatient treatment services providing for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological other than methadone).

Note: If you need more specific information on definitions or on how to fit data organized according to the prior year separate alcohol and drug matrices into this year's one combined matrix please don't hesitate to call NASADAD staff.

APPENDIX B

STATE-BY-STATE POPULATION, PER CAPITA INCOME, POPULATION DENSITY AND STATE REVENUE FIGURES

STATE-BY-STATE POPULATION, PER CAPITA INCOME, POPULATION DENSITY AND STATE REVENUE FIGURES

STATE	CIVILIAN POPULATION JULY 1, 1989	1988 PER CAPITA PERSONAL INCOME	JULY 1, 1988 POP. DENSITY (per sq. mile)	APPROPRIATED FY 1989 STATE EXPENDENDITURES (in millions)
ALABAMA	4,096,000	13,679	80.7	6,955
ALASKA	502,000	21,173	.9	3,195
ARIZONA	3,530,000	15,881	31.1	5,373
ARKANSAS	2,397,000	12,984	46.0	4,359
CALIFORNIA	28,757,000	19,740	184.0	61,242
COLORADO	3,274,000	17,494	31.6	5,118
CONNECTICUT	3,224,000	24,604	661.7	2,006
DELAWARE	668,000	19,116	345.8	2,006
DISTRICT OF COL	597,000	23,436	9,476.2	3,828 A
FLORIDA	12,565,000	17,694	232.0	21,256
GEORGIA	6,367,000	16,188	109.7	9,888
GUAM	120,900	N/A	506.3	N/A
HAWAII	1,056,000	18,306	164.4	3,204
IDAHO	1,009,000	13,762	12.2	1,549
ILLINOIS	11,622,000	18,858	208.9	18,610
INDIANA	5,587,000	16,005	155.5	8,225
IOWA	2,839,000	15,524	50.7	7,323
KANSAS	2,488,000	16,182	30.4	4,239
KENTUCKY	3,694,000	13,777	93.1	6,801
LOUISIANA	4,351,000	13,041	97.7	8,387
MAINE	1,213,000	16,310	39.1	2,492
MARYLAND	4,642,000	21,020	471.9	10,028
MASSACHUSETTS	5,900,000	22,196	754.1	16,469
MICHIGAN	9,263,000	17,745	162.6	15,981
MINNESOTA	4,351,000	17,746	54.7	9,333
MISSISSIPPI	2,603,000	11,835	55.1	4,105
MISSOURI	5,143,000	16,431	74.6	7,036
MONTANA	801,000	13,852	5.5	1,287
NEBRASKA	1,598,000	15,360	20.8	2,364
NEVADA	1,099,000	18,827	10.0	1,573
NEW HAMPSHIRE	1,102,000	20,251	122.5	1,484
NEW JERSEY	7,716,000	23,764	1,033.2	16,302
NEW MEXICO	1,513,000	13,191	12.5	3,033
NEW YORK	17,916,000	20,540	378.2	42,068
NORTH CAROLINA	6,467,000	15,221	132.4	10,410
NORTH DAKOTA	650,000	13,261	9.4	1,474
OHIO	10,895,000	16,499	265.7	19,589
OKLAHOMA	3,194,000	14,151	46.5	5,605
OREGON	2,818,000	15,785	29.3	6,196
PENNSYLVANIA	12,028,000	17,422	268.0	20,953
PUERTO RICO	3,292,000	N/A	962.3	N/A
RHODE ISLAND	992,000	18,061	940.3	2,091
SOUTH CAROLINA	3,450,000	13,616	114.2	6,942
SOUTH DAKOTA	708,000	13,244	9.3	1,177
TENNESSEE	4,920,000	14,765	119.5	6,763
TEXAS	16,855,000	15,483	64.3	18,533
UTAH	1,701,000	13,027	20.7	2,840
VERMONT	567,000	16,399	61.1	1,148
VIRGIN ISLANDS	106,000	N/A	803.0	N/A
VIRGINIA	5,928,000	18,970	149.3	11,393
WASHINGTON	4,704,000	17,640	70.7	9,839
WEST VIRGINIA	1,856,000	12,529	77.0	3,521
WISCONSIN	4,865,000	16,759	89.4	10,244
WYOMING	471,000	14,135	4.9	1,206
UNITED STATES	250,070,900	17,567		459,298.0

N/A = Information not available.

A = Estimated State Expenditures for D.C. are 1988 estimated funds.
B = Population estimates for Guam, Puerto Rico, and the Virgin Islands are for 1988.

State Civilian Population data from United States Department of Commerce, Bureau of the Census, 'Current Population Reports', Series P-25, No. 1058.

Per Capita Personal Income data from United States Department of Commerce, Survey of Current Business, April 1990, Page 58, Table 4.

State Population Density is calculated by dividing the State civilian population estimates for 1989 by the State land area in Square Miles.

State Government Expenditures are from State Expenditure Report: 1989; by the National Association of State Budget Officers, 1989

APPENDIX C

STATE MODEL PRODUCTS AVAILABLE AND CONTACT PERSONS

STATE MODEL PRODUCTS AVAILABLE AND CONTACT PERSONS

ALASKA:

- Counselor Certification Standards - Teresa Staley - (907) 243-1181
- Economic Cost of Alcohol & Drug Abuse - David Pierce - (907) 586-6201
- Statewide Student Drug Use Survey - Bernard Segal, Ph.D., - (907) 786-1801
- Alcoholism Treatment Outcome Study - Matthew C. Felix - (907) 586-6201

ARKANSAS:

- Early Intervention Program - John Brownlee
- Chemical Free Living Centers - John Chmielewski
- Department of Corrections Substance Abuse Treatment Program - Boyce Brewer
- Employee Assistance Program - Ron Bass

CALIFORNIA:

DRUG PROGRAMS DIVISION

- California's Continuing Response to HIV Disease, a Strategy Plan - California AIDS Leadership Committee - Lura Franzella
- County Review Manual - Allan Harlow
- Program Review Manual - Allan Harlow
- Methadone Regulations, California Administrative Code, Title 9 - Dick Swart
- Prevention Standards - Paul Wyatt

ALCOHOL PROGRAMS DIVISION

- Fetal Alcohol Syndrome (Training of Trainers) Manual - Elaine Dokimos

- Black Parenting Skills (Curriculum) Manual - Elaine Dokimos
- How to Start Women With Children Programs Manual - Elaine Dokimos
- Working With Hispanic Women Manual - Elaine Dokimos
- Foto Novela (Photo Novel) Manual - Elaine Dokimos
- Alcohol-Related Birth Defects Report - Noralee Jennings-Bradley
- Friday Night Live Chapter Booklet, Slide Show and Curriculum - Karen Stroud
- California Youth Council Report - Karen Stroud
- Learn to Say No Campaign - Marshal D. Wilkerson
- Framework for Community Initiatives - Marshal D. Wilkerson
- Standards for Prevention Programs Manual - Marshal D. Wilkerson
- Drug Prevention Program Marketing Manual - Marshal D. Wilkerson
- Curriculum for Drug Abuse Prevention Practitioners Manual - Marshal D. Wilkerson
- Manual on Community Planning to Prevent Problems of Alcohol Availability - Mary Huttner
- Alcohol Beverage Control: A Public Health Perspective - Mary Huttner
- Licensing and Certification Standards - Roger Thompson
- Directory of Licensed Drinking Driver Programs - Joy Jarfors
- Drinking Driver Program Licensing Regulations - Joy Jarfors

PLANNING AND EVALUATION DIVISION

- State Master Plan - David Monti
- Request for Application - County Master Plan Project to Implement SB2599 - David Monti

- Indicators of Alcohol and Drug Abuse Trends - Susan Nisenbaum

COLORADO:

- AIDS Regulations for Licensed Alcohol and Drug Treatment Programs - Chris Olson
- Updated Counselor Certification Regulations - Chris Olson
- Revised Licensing Standards - Chris Olson
- Standards for Prevention Professionals - Fred Garcia

CONNECTICUT:

- The State Agency is establishing and supporting Regional Substance Abuse Action Councils (RACs) in Connecticut. RAC is a public-private partnership comprised of area leaders. Its purpose is to establish and implement an action plan to develop and coordinate needed services in the field of substance abuse - Clifford Laube
- Mainstreaming Treatment of Elderly Substance Abusers - Robert Savage
- Mainstreaming Treatment of Deaf and Hearing Impaired Substance Abusers - Robert Savage
- HIV Education, Counseling and Testing in Substance Abuse Treatment Programs - Robert Savage
- Methadone to Abstinence Program (client's participation limited to one year) - Robert Savage
- Program to Treat TB Infected Clients in Methadone Treatment Programs - Robert Savage
- Court Liaison Program (for monitoring and planning of court referred clients) - Sandra Sunderland
- P.A. 89-390: New system for court ordered referrals to treatment - Sandra Sunderland
- Victims Impact Panel (with MADD) - Sandra Sunderland and John Rimetz
- Counselor Certification - Willie Colon
- ARROW Program (AIDS outreach) - Willie Colon

- Workplace Programs - Willie Colon
- Funding Regulations - Willie Colon
- Governor's Public/Private Partnership - Clifford Laube
- Fiscal Monitoring Review Guide - Helen Merli
- Program Monitoring Review Guide - Willie Colon
- March 1, 1989 - The Drug and Alcohol Abuse Crisis Within the Connecticut Criminal Justice System -Julie Konopka

DELAWARE:

- "Above the Influence" Treatment Program - Benetia Williams, Governor's Office - (302) 571-3210
- Program Licensing Standards - Marcia Fernandez-Hermo - (302) 421-6177
- Contract/Program Monitoring Protocol - Marcia Fernandez - Hermo - (302) 421-6177
- Aftercare/Continuing Care (Criminal Justice Clients) - Howard Isenbeg - (302) 429-5928

DISTRICT OF COL.:

- CADA (Corporations Against Drug Abuse) Model Prevention Project - Larry Heures - (202) 338-8993
- Plans for Comprehensive Addicted Women's program - Evelyn Vance, Special Assistant to the Administrator - (202) 727-0762
- Operation Fightback (Citywide Prevention/Intervention/ Treatment Model) - Shirley Wilson, Chief, Office of Criminal Justice Plans Analysis - (202) 727-6537
- IMPACT (Integrated Methods to Prevent Addictions in Children and Teens), Vernease Herron - (202) 673-7481

FLORIDA:

- All contacts can be reached at (904) 488-0900
- Guidelines for Client Admissions - Phil Emenheiser
- Guidelines for Detoxification - Phil Emenheiser

- Statewide Epidemiology Workgroup Proceedings 1988 - Doug Lees
- Statewide Epidemiology Workgroup Proceedings 1989 - Doug Lees
- Employee Assistance Program Technical Assistance Package - Chuck Rabaut
- Signs, Symptoms and Comforting Techniques for Infants Affected by Substance Abuse - Terri Goens
- Specialized Treatment Programs for Pregnant/Post-Partum Women - Terri Goens
- Methadone Treatment in Florida - Phil Emenheiser
- CODAP Manual - Melissa Rivas
- Florida AIDS Services Manual for Substance Abuse Providers - Jerry Swank
- Florida Drug-Free Workplace Act - Renee Morgan
- Grant Resources List - Roger Crescentini

GEORGIA:

- Prevention Resource Center
- AIDS Policies
- Standards for Student Assistance Programs

HAWAII:

- AIDS: Policies of Treatment Non-discrimination, Bleach, Teach and Preach Method
- Coupons for Free Detox at Methadone Clinic - John McCarthy
- Counselor Certification - Patricia S. Hunter

ILLINOIS:

- A Plan for Drug Free Families with a Future - Linda Hargnett
- Illinois Women's Needs Assessment for Alcoholism and Substance Abuse Treatment - Linda Hargnett

- The Illinois Youth Substance Abuse Screening Project - Linda Hargnett
- "Families In Touch" prevention publications, a series - Alvera Stern
- "Steroids - You're Cheating Yourself" educational campaign - M. Bishop

INDIANA:

- Program Certification Standards
- Rules for Approval of Business-Based Alcohol/Drug Prevention Programs

IOWA:

- New AIDS legislation - third party notification - Cheryl Christie (515) 281-4938
- Licensure Standards - to include quality assurance and utilization review

KANSAS:

- Residential Youth Treatment Program
- Prevention Evaluation - Statewide System
- Governor Mike Hayden's "Toward a Drug-Free Kansas"
- State Employees Drug-Free Workplace Program, Kansas Department of Administration (913) 296-4352
- AIDS Policy
- Regional Prevention System
- School Team Training

KENTUCKY:

- Champions Against Drugs - Statewide Prevention Program - Barbara Stewart - (502) 564-2880
- Group Home Loan Program - application package - Hugh Spalding - (502) 564-3487

LOUISIANA:

- Statewide AIDS Policy - Rupert Richardson
- Statewide Directory of Alcohol and Drug Abuse Resources - Suzanne DeRousselle
- Guidelines for DWI Programs - Sanford Hawkins
- Revolving Fund for Recovery Homes - Ralph Campbell
- Licensing Standards for Substance Abuse Programs - Bob Perkins

MAINE:

- Office of Alcoholism and Drug Abuse Planning Committee - Don Lund - (207) 289-2595
- Maine's Department of Education & Cultural Services, Division of Alcohol & Drug Education - Carl Mowatt - (207) 289-6500
- Community Youth Projects - Neill Miner, OADAP - (207) 289-2781
- Tenants' Assistance Program, Madeline Spadola, Bur. of Elder & Adult Services - (207) 289-2561

MICHIGAN:

- Fundamentals of Substance Abuse Counseling - manual/curriculum and examination
- "Effective Substance Abuse Counseling with Specific Population Groups" - manual/curriculum and examination
- Certified Addictions Counseling (CAC) Credential
- Model Program for Pregnant Addicted Women
- Substance Abuse Curriculum Designed to Instruct Individuals Trained in American Sign Language to Provide Casefinding Services within the Hearing Impaired Community

MINNESOTA:

- A Treatment Method for Facilitating the Recovery of Chemically Dependent Women; available at Print Communications Division - (612) 297-3000
- Model Treatment Program for Chemically Dependent Women, Resource Manual; available at Print Communications Division - (612) 297-3000
- Minnesota Directory of Services for Chemically Dependent Women and Their Children; available at Print Communications Division - (612) 297-3000
- Process Parenting - Breaking the Addictive Cycle; available at Print Communications Division - (612) 297-3000
- Training Tapes for Working with Chemically Dependent Older Adults, Physically Disabled, and Mentally Ill, Sharon Johnson, (612) 296-4711
- HIV Guidelines for Chemical Dependency Treatment and Care Providers - Earl Pike - (612) 296-4767
- Hearing Impaired Tapes; available at Print Communications Division - (612) 297-3000
- T.V. and Radio Prevention Spots; Party Straight Theme - Sharon Johnson - (612) 296-4711
- Womens Issues Video Tape - Sharon Johnson - (612) 296-4711
- Borrow Me A Quarter, The Cost of Providing Services to Chronic Users - Wayne Raske - (612) 296-2174
- Assessment Training Curriculum - Karen Edens - (612) 296-8573
- Placement Criteria - Lee Gartner -(612) 296-8574
- Inpatient vs Outpatient Treatment, A Comparative Study - Michael McMahon - (612) 297-4079
- 1989 Minnesota Household Survey of Drug and Alcohol Use Among Adults - Paul Wiener - (612) 297-1863
- Perinatal Drug Abuse Legislation and Funding - Wayne Raske - (612) 296-2174

- State Epidemiology Work Group; contact Carol Falkowski, - (612) 296-4616
- Consolidated Chemical Dependency Treatment Fund Information (law, rules, reports) - John Gostovich - (612) 296-4608
- Directory of Chemical Dependency Programs in Minnesota - Carl Haerle - (612) 296-4614
- Drug and Alcohol Abuse Normative Evaluation System (DAANES) - Carl Haerle - (612) 296-4614

MISSISSIPPI:

- Drug Free Workplace Policy and Procedures - Ann D. Robertson, MSW

MISSOURI:

- Statewide Parent Resource Network - Randy Smith
- School/Community Team Training Program - Jodi Haupt
- Model Program - Women's and Children's Center - Bob McClain
- Model Program - Adolescent Center - Bob McClain
- Model Program - Services for Family Members - Bob McClain
- New Facility Requirements for Residential Treatment Centers - Bob McClain

MONTANA:

- Counselor Certification Standards
- Treatment Approval and Evaluation Standards
- Administrative Rules
- AIDS Policy for State of Montana and Institutions

NEBRASKA:

- Program Certification Standards - Romeo Guerra
- Drug Free Workplace Policy - Romeo Guerra

NEVADA:

- Alternative Activity Programs for High Risk Youth - Kathy Bartosz
- Statewide EAP Conference/Training - Sharyn Peal

NEW JERSEY:

- Combined Alcoholism/Drug Treatment Counselor Certification - Norm Salt
- N.J.A.C. 8:66; Intoxicated Driver Resource Center (Proposed regulations) - Dave Evans
- N.J.A.C. 8:31 C-1; Rate Setting Regulations for Alcoholism Rehabs - Wm. Barstow
- P.L. 1989: C.51; Creates the Governor's Council on Alcoholism and Drug Abuse and the Alliance for a Drug Free New Jersey - Riley Regan

NEW YORK:

DRUG ABUSE DIVISION

- Homeless Project - John Gustafson - (518) 457-7629
- Key Extended Entry Program/KEEP - John Carway - (212) 870-8357. (This is a methadone maintenance regimen that consists of three components designed to direct IV drug users toward referral to long-term treatment: orientation; evaluation; and classification)

NEW YORK:

ALCOHOL DIVISION

- Standards for the Operation of Community Residences for Alcoholism (Halfway Houses, Recovery Homes, Supportive Living Facilities) - William T. Tyrrell
- Standards for the Operation of Residential Chemical Dependency Programs for Youth - William T. Tyrrell
- Standards for the Operation of Alcoholism Facilities - William T. Tyrrell
- Standards for Operation of Inpatient Alcoholism Programs - William T. Tyrell

- Standards for the Operation of Outpatient Facilities and Programs - William T. Tyrrell

- Responsibilities of Facilities for Alcoholism in Regard to AIDS, HIV Illness and HIV Related Information, 14NYCRR 309 - William T. Tyrrell

- Extending the Alcoholism Treatment Mandate to Inpatient Services, a Report in Support of the Governor's Program, Bill #2, May 1, 1989 - William T. Tyrrell

- Prevention/Education Products

Title of Publication	Type
1. Alcohol & Drugs on the Job	Brochure for Employees/Unions
2. Alcohol and Your Health	Coloring Book for Young Children (S)
3. Alcohol: How Much is Too Much?	Brochure*(S) & Poster*
4. Alcohol: Kids and Teen-agers	Brochure
5. Alcohol: Some Thoughts for Parents	Brochure
6. Alcohol: The Gateway Drug	School Curriculum
7. COAs & Alcohol - Risky Business	Brochure*(S) & Poster*
8. Don't be Fooled. This is a Drug (Wine Cooler)	Poster*
9. Do You Use Drugs? (Beer)	Poster*
10. EAP - A Profitable Investment in Employee Health	Booklet for Employers/Unions
11. Fetal Alcohol Syndrome Professional Packet	Health Educators Kit
12. FYI: The Warning Signs of Alcohol Problems	Brochure*
13. FYI: Alcoholism Treatment Works	Brochure

14.	Getting Drunk is Never Safe	Poster (S)
15.	Guidelines for College Campuses	Program Manual
16.	Hospital Intervention Services	Program Brochure - Health Facilities
17.	Is It Safe to Drink While I'm Pregnant?	Poster (S)
18.	Law Enforcement Officers and Alcohol	Brochure
19.	Questions and Answers About Alcohol	Brochure*
20.	Think. You Don't Have to Drink	Brochure for Teens
21.	Warning: Alcohol Can be Hazardous to Your Unborn Baby's Health	Brochure (S)

Brochures and posters - up to 50 copies free with a written request. Quantities of other material may be limited.

(S) - Publications available in Spanish.
* - Publications available at cost in bulk through the New York State Clearinghouse for Alcohol Information, 1-800-ALCALLS.

To Order, write to the Bureau of Community Education and Intervention, NYSDAAA, 194 Washington Ave., Albany, NY 12210

Note: Out-of-state requests may be limited to 25 copies depending on availability.

- Information Briefing on Credentialling of Alcoholism Counselors in New York State - Mary Corrigan
- The Alcoholism Primer - Bureau of Professional Development
- Self Instructional Manual - Bureau of Professional Development
- Guidelines for Designing Competency - Based Staff Development Programs - Bureau of Professional Development

- Trainer Manual: Alcoholism Counseling: Core Curriculum - Bureau of Professional Development

- Trainer Manual: Clinical Supervision - Bureau of Professional Development

- Trainer Manual: Theories of Co-dependency - Bureau of Professional Development

- Trainer Manual: Group Skills for Alcoholism Counselors - Bureau of Professional Development

- 1990 Update to the Five-Year Comprehensive Plan for Alcoholism Services in New York State - Timothy Williams - (518) 474-6427

- 1989 Report on Special Programming for Women - Timothy Williams - (518) 474-6427

- Data Supplement to the 1990 Local Services Plan Guidelines (Includes methods for need methodology) - Jean Audet - (518) 474-6427

- Waiting Lists and the Need for Alcoholism Services, Brief Report - Bob Gallati - (518) 474-6427

- Women and AIDS Project: A Model for Government-Constituent Interaction (includes availability of quarterly newsletter) - Lynn McArthur - (518) 474-6427

NORTH CAROLINA:

- Adolescent SA Training for Youth Professionals - 30 Hour Curriculum - Spencer Clark - (919) 733-4555

- AIDS Health Protection Guidelines - Robert J. Allen - (919) 733-4506

NORTH DAKOTA:

- Counselor Licensure Standards - Sue Stenehjem-Brown - (701) 663-2321

OHIO:

- Driver Intervention Program Cost Reimbursement System - Walter Hull

- Teenage Institute on Alcohol and Other Drugs - Rob Steele

- Ohio Drug and Alcohol Studies Institute - Sylvia Walker
- Program Certification Standards Process - Roger Kenton
- Fiscal Information System - Lynn Crevling

OKLAHOMA:

- AIDS Policies - Paula Grove

OREGON:

- Drug Free Workplace Policies - Shawn Clark
- Marijuana Diversion Law - Clark Campbell
- Statewide Adolescent Prevalence Survey - Marilyn Wachal
- Legislation Requiring Mandatory Alcohol and Drug Policy, Plans and K-12 Curriculum for All School Districts and Higher Education Institutions
- Statewide Family Training Program in How to Reduce High Risk Factors for Early Onset of Alcohol, Tobacco and Marijuana Use
- Model Planning Process to Serve Addicted Clients Throughout State Agencies

PENNSYLVANIA:

- Teen Pregnancy/Parenting Program and Evaluation - Joyce Robertson
- Student Assistance Program - Joyce Robertson
- Treatment Alternatives to Street Crimes - Gloria Martin-Payne
- Comprehensive Prevention/Intervention Program for School and Evaluation - Joseph Villone
- Women and Children Residential Treatment Program - Hector Gonzalez
- Convened a Statewide Maternal Addictions Task Force to Develop a Multi Disciplinary Approach for Residential Treatment of Pregnant Addicts - Hector Gonzalez

- Personal Computer Based Client Information System Currently in Testing Phase. Will enable information flow from facility to county to state control office - Scott Kister

PUERTO RICO:

- Innovative Detoxification with Accupunture Program - Dr. Carlos Robles, Assistant to the Secretary on Medical matters

RHODE ISLAND:

- R.I. Board for the Certification of Chemical Dependency Professionals (Counselor Certification - Linda Duquenoy)
- Bramley Bill (R.I. Substance Abuse Prevention Act) - Legislation which provides funding for municipal prevention programs through directing revenues from motor vehicle violation penalties into a restricted receipt account specifically for funding drug prevention programs - Linda Duquenoy
- R.I. Student Assistance Junior High/Middle School Act (Bramley II) - Legislation which provides for student assistance programs in junior high/middle schools, based on the Westchester County model, through monies raised by assessing an additional penalty of $20.00 for all motor vehicle violations into a restricted receipt account specifically for funding Rhode Island Student Assistance Junior High/Middle School Act - Linda Duquenoy
- Joint Education Committee - Created to approve submitted courses, workshops, trainings, etc., for CEU's - Linda Duquenoy
- MHRH - Drug Free Workplace Policy - Linda Duquenoy
- Model "School Substance Abuse Policy Guide" (K-12) - Linda Duquenoy
- Model "Children of Alcoholics Prevention Program" (ages 3-18) - Linda Duquenoy
- Human Ecology Program (K-12) Substance Abuse Curriculum - Linda Duquenoy
- Peer Education Program - Linda Duquenoy
- Substance Abuse Resource Guide - Linda Duquenoy

- The Governor's Guide for the Prevention of Alcohol and Drug Abuse - Linda Duquenoy
- The Working Task Force - Linda Duquenoy
- R.I. Integrated Alcohol and Drug Treatment Program Matrix - Combines the recommendations of the Alcohol and Drug Studies for future expansion of the treatment system by modality and geographic area
- Licensing Standards
- 1982 Legislation Regarding Driving While Intoxicated and Subsequent Amendments - Jo Ann Cotnoir
- 1989 Legislation Mandating a Drug Treatment and Education Program - Jo Ann Cotnoir
- TASC Program, component of Division of Substance Abuse - Jo-Ann Cotnoir
- After 9/30/90 - Curriculum for Mental Health Workers - Dually Diagnosed

SOUTH CAROLINA:

- School Alcohol and Drug Use Survey - Ned Self
- Quality Assurance Standards - Sarah Meadows
- Medicaid SOP Manual - Bob Hill
- HIV Seroprevalence Study - Linda Nalty

TENNESSEE:

- Drug Testing Training Manual - Jackie Bruce - (615) 741-4242
- Juvenile Correctional Alcohol and Drug Programs - Gary Woodward Smith - (615) 741-1924
- Short Term Family Counseling - Belinda Sears - (615) 741-1924
- Early Intervention - Tommy Brame - (615) 741-1924
- Youth Highway Safety - Ira Lacy - (615) 741-4458

TEXAS:

- TCADA Resource Directory for Substance Abuse Professionals
- Epidemiology Studies of Texas Substance Abuse: School Students, Adults and Justice Population
- Pharmacological Consequences of Drugs of Abuse
- Licensure Standards

UTAH:

- Licensing Standards - Kent Callister - (801) 538-4237
- Drug-Free Workplace, State Policy - Lorraine Furia - (801) 538-3939
- Incidence and Prevalence Studies, 1989: Youth and Adult Survey Results - Alan Sherwood - (801) 538-3939
- Local Authority Service Delivery Systems - Leon PoVey - (801) 538-3939
- Community, Youth Activity Program Demonstration Project - Alan Sherwood - (801) 538-3939

VERMONT:

- Day Care/Foster Care for Women in Treatment - Tim Mailly
- Medicaid Reimbursement for Substance Abusers - Tim Mailly
- Treatment Evaluation - Stuart Friedman
- Drug Testing Legislation that Enhances Civil Rights of Workers - Stuart Friedman
- Pre-screening Criteria, Procedures and Protocol for Persons Seeking Admission to Residential Treatment - James Bellino

VIRGINIA:

- Legislation which Provides for the Loss of Driving Privileges for Youth Convicted of Any Alcohol/Drug Abuse Offenses (Use and Lose) - Ken Batten

- Research and Program Models for Adolescent Dual Diagnosis Treatment - Greg Stolcis
- Comprehensive Interagency Substance Abuse Plan 1989 - Mellie Randall
- Department of MHMRSAS Policy for the Management of Clients with AIDS and the Services Related to the Needs of Those Clients - Barry Wall

WASHINGTON:

- Omnibus Drug Act (Includes Alcohol/Drug Services) - Chris Hansen
- Continuum of Treatment for Pregnant/Post Partum Women - MaryAnn LaFazia
- Adolescent Treatment Guide - Chris Hansen
- Evaluation of Pilot Employment Programs (Treated Clients) - Chris Hansen
- Certification Rules/Standards, and Checklists for Inspections - Dave Curts
- Protective Payee Pilot Project Study - Chris Hansen
- Community Prevention Task Force Handbook - Deb Fouts

WEST VIRGINIA:

- WV Adolescent Services Plan - Dorian Severino - (304) 348-2276
- Standards for Residential Treatment Units & Transitional Living Facilities - Gary Koontz - (304) 348-2276
- Model Program for Shelter & Evaluation of Public Inebriates - Toni Estep - (301) 345-4800
- Union/Management Occupational Prevention/Awareness Project - Frank Fantauzzo - (304) 345-5811

WISCONSIN:

- Drug-Free Workplace Policies - Vince Ritacca
- Alcohol and Drug Abuse Annual Indicators - Mike Quirke

- Treatment Alternatives Program Model - Oren Hammes
- Position Paper on Alcohol and Other Drug Abuse and the Hearing Impaired - Robert Fry
- Updated Student Assistance Program Manual - Sara Krebsbach
- Youth AODA Task Force Report - Lou Oppor
- Employee Assistance Program Standards and Monitoring Criteria - Vince Ritacca
- Trainer's Manual for Student Assistance Program Team Training - Sara Krebsbach

APPENDIX D

STATE NARRATIVE REPORTS ON MAJOR UNMET NEEDS

STATE NARRATIVE REPORTS ON MAJOR UNMET NEEDS

ALABAMA:

Training: Existing staff within system and new staff for emerging adolescent programs - Need funds, experience opportunity, and qualified trainers (need ongoing, sustained effort).

Women's: Brief residential and halfway residential with child care - Need funds, facilities, willing providers.

Intensive Outpatient Programs, Both Adult and Adolescent: Need trained staff and funds.

Statewide T.A.S.C. program: Need funds and people.

ALASKA:

Appropriate treatment services for adolescents; $1,500,000.

More comprehensive services for homeless/public inebriates; $1,500,000.

Development and implementation of improved community services in rural, Alaska Native communities; $800,000.

Establish an inhalant abuse prevention program; $300,000.

ARIZONA:

The influx of soon-to-be-awarded increased substance abuse funds makes an assessment of "inadequate" resources a bit difficult. However, a list of needs would include:

- Strengthening the financial infrastructure for personnel in the poorly paid substance abuse treatment community.
- Refurbishing facilities.
- Adding youth treatment facilities and staff with training and experience.

- Promoting the development of facilities in the northern portion of Maricopa Country.

ARKANSAS:

Comprehensive treatment services for youth; specialty programs for minorities and women; services for dually diagnosed.

All of the above are needed, particularly non-categorical funding that would allow the Single State Agencies to adapt funding mechanisms to treatment and prevention demands.

CALIFORNIA:

DRUG PROGRAMS DIVISION

Additional funding to increase the number of women-specific alcohol recovery and drug treatment programs for women and their children.

Additional funding to provide technical assistance to agencies seeking to assess the need for perinatal alcohol and drug services. Also, to assist these providers in developing comprehensive systems of perinatal service delivery.

Residential services for both adolescents and adults are needed. Locating facilities continues to be a problem, as well as funding, staffing and training.

Additional funding to increase AIDS prevention efforts, particularly outreach to high-risk populations.

Additional funding to increase treatment services on demand, i.e., waiting list reduction programs.

Additional funding to provide training to administrative and frontline personnel who work with drug abusers at high-risk of contracting and spreading the human immunodeficiency virus.

ALCOHOL PROGRAMS DIVISION

Program Assistance Section

Women's recovery services.

Adolescent recovery services.

Hispanic-American recovery services.

Disabled recovery services.

Aged recovery services.

Children of alcoholics recovery services.

Youth Prevention Services

The California Friday Night Live (FNL) Program is attempting to provide technical assistance, training, and resource development to 34 county FNL programs and a number of chapters throughout the State.

To continue at this level, we need to add an FNL Program Director, a Resource Development Coordinator, and a Technical Assistance and Training Coordinator. To increase the number of county FNL programs, an additional $250,000 is needed to provide supplemental support, seed monies, and regional conference support.

Intervention and Recovery Services

Additional funding is needed to strengthen existing recovery and prevention programs for targeted high risk groups, e.g., drug-addicted babies, youth and women.

Resource development in the areas of drug and alcohol-related prevention. Continuing support of state and community programs through the federal clearinghouse functions and the national research/resource centers.

COLORADO:

We have a good, cost efficient system for the average client but lack resources to provide adequate services for special need groups.

There needs to be a reporting and data collection system for addicted infants.

CONNECTICUT: The recent three-year plan entitled the "Governor's Interagency Plan on Youth Substance Abuse Prevention and Intervention" identified many prevention "needs" in the state, for example, the need for:

Development of interagency collaboration.

AIDS prevention.

Addicted neonates.

Special populations, e.g., infants, pregnant women, elderly, minorities.

Areas identified in Governor's Interagency Plan.

In the treatment area, the State Agency has identified the following needs:

Expansion of alcohol and drug residential detoxification and intensive care programs.

Expansion of alcohol and drug intermediate care programs.

Development of Sobering Up Centers for chronic recidivist alcoholics.

Expansion of capacity to treat substance abusing pregnant women.

Expansion of alcohol and drug outpatient drug free programs.

DELAWARE: Development of additional community programs for severely disabled, alcohol/drug abusers and IV drug users.

Additional residential options, especially for drug abusers - current services are insufficient to meet the demand.

Additional outpatient capacity for drug and alcohol abusers - current services are insufficient to meet the demand.

DISTRICT OF COL.: The District admitted in excess of 12,000 patients to outpatient and inpatient treatment services this fiscal year. In addition, over

75% of the visits to the public health system were for drug treatment. In order to measure and manage the services and thereby provide quality treatment, the Commission of Public Health needs to develop a state of the art information management system. Funding for this project was not available.

The District's training system was not funded after federal support was ended in 1983. The District needs to develop training materials and trainers to support public and private alcohol/other drug treatment and prevention programs. Funding was not available to provide alcohol and drug training.

FLORIDA: Major needs in the State continue to center around the need for expanded or new programs in the areas of child services, women's issues, cocaine babies, expanded capacity. This creates a demand for improvements and upgrades in facilities and for additional staff. To keep and hire staff, salaries in general need to be increased.

GEORGIA: Research - funds and staff.

Facilities - funds.

Comprehensive training institute - staff, equipment.

Treatment for women and children - training, facilities.

Urine drug screens - funds.

EAP programs - training.

GUAM: Presently, there are insufficient funds to support a free-standing residential facility for drug and alcohol clients. Moreover, there is a current need of trained counselors with drug and alcohol treatment experience.

HAWAII: Information management system and data collection - hardware, software, trained staff; training institute or network - qualified training staff.

Residential and day programs for pregnant mothers and drug exposed babies - all resources needed.

Adolescent services - all resources needed.

Social detoxification services on neighbor islands - all resources needed.

Statewide planning - technology training, staff.

IDAHO: Adolescent residential treatment: currently, the only residential treatment resources for adolescents in Idaho are private-for-profit hospital-based programs. These programs are not accessible to persons without insurance and considerable private funds. There is a need for public funds to support residential treatment for adolescents. The program has been unwilling to divert funds from adult treatment programs due to the already over utilization of these programs. The Department has requested that the Governor include in his FY 91 budget request, funds for adolescent treatment. There is considerable optimism that this will be achieved this year.

ILLINOIS: Recruitment, training, and retention of treatment and prevention staff.

Services for the dually diagnosed (mental illness plus abuse/addiction).

Services for women, particularly the pregnant addict/abuser. Recruitment into treatment and retention of intravenous drug users.

Services to homeless (poor social support systems); systems infrastructure support; capital development.

Systems flow through - geographic availability and financial accessibility for appropriate levels of care as needed for individual clients.

INDIANA: Expansion of adolescent treatment services.

Treatment services for incarcerated populations.

IOWA: Need additional money to improve facilities and salaries.

Need money to do adequate follow-up.

Continuation of care needs to be expanded, especially for minority populations.

Difficult to access counselors, especially for minority populations.

KANSAS: Major needs include: continuum services for indigent youth and completion of regionalized prevention programming and upgrading of existing treatment programs and facilities. Funding is needed to expand the programming, repair or replace facilities, upgrade staff and technology. Legislation is needed for mandatory credentialing.

KENTUCKY: Major needs include: transitional care for chemically dependent adolescents; residential non-hospital treatment for adults; long term residential treatment for adolescents (chemical dependency with behavior problems); increasing treatment capacity for IV drug users; early intervention (student assistance programs) in public schools, social service system and juvenile justice system; and decentralization of prevention services to regional resource centers.

LOUISIANA: The major problems experienced in the field of substance abuse in Louisiana are detoxification services, services for the dually disabled, lengthy waiting periods for all services, and inadequate treatment for cocaine abusers. Inadequate funding contributes to all of these problems and is the major factor in the second and third problems listed above. In the case of detoxification services, however, the attitude of the medical profession is a significant contributing factor, with groups of medical doctors opposing social detoxification services on the one hand and obstructing the provision of medical detoxification services on the other. The problem involved in cocaine abuse is simply the ineffectiveness of traditional treatment techniques.

MAINE:	Sufficient dollars to maintain service system.
	Implementing the funded comprehensive effectiveness data/accountability system.
	Effective ways to tie our treatment and prevention services to other human service systems.
MARYLAND:	Major service needs include residential and intensive outpatient services for adults and adolescents, specialized programming for women, additional assessment/evaluation services to courts, additional family therapy/services in all treatment modalities. Major barriers to meeting these needs are limited fiscal resources, and facility issues, i.e., a) inability to locate appropriate new service delivery sites where zoning and neighborhood acceptance are not issues; b) age and physical conditions of some current facilities dictate relocation or renovation.
MASSACHUSETTS:	Pregnant women - facilities, skilled staff, technology, liability insurance.
	Treatment in correctional facilities - facilities, funding, staff.
	Civil commitments for treatment - facilities, funding.
MICHIGAN:	There are not adequate resources for services to special populations.
	Training funds for statewide training efforts are not adequate.
	There is no funding for capital improvements and salary levels in the field remain low. As treatment dollars have expanded, the additional funding has gone into expanding treatment.
	Reimbursement for treatment services is also low.
MINNESOTA:	Improved services for South East Asians and Hispanics
	Adequate funding for treatment.

Funding alternatives for chronic patients, including housing and employment.

Treatment for pregnant women.

MISSISSIPPI: There seems to be a lack of opportunities for programs to receive adequate training in treating the increased admissions for cocaine abuse.

MISSOURI: Current funding levels do not provide sufficient resources to provide a minimum acceptable floor of services. Over 800 people are waiting to receive treatment. There is a waiting list for schools to receive prevention programming. There is also a need for adequate treatment resources for and public education targeted to pregnant substance abusing women. Additional funding is also needed to aid in the recruitment and retention of skilled substance abuse counselors in public funded treatment programs.

MONTANA: Major needs for which resources are not adequate continue to be:

Transitional living facilities for men, women, and youth (funds and facilities);

Detoxification and inpatient beds for indigent adult and youth (funds);

Lack of outreach and inpatient services in rural Montana (funds and staff);

State of the art treatment and prevention programs for cocaine and crack (training);

Indigent IV drug users on waiting lists and additional and funds for inpatient (funds);

Increased outreach efforts to IV drug users. A contract in the largest Montana community has been implemented. Unable to gauge increased needs at this time;

Expansion of prevention efforts to include increased collaboration among agencies within communities and at the State level.

NEBRASKA: Treatment and prevention services for youth-funds and appropriate staff.

Emergency detoxification services - funds and facilities.

Youth and adult partial/day care program - effectiveness in rural areas.

Evaluation methodology - technology, staffing, training.

NEVADA: We recently identified unmet needs and are currently in the process of prioritizing them.

NEW HAMPSHIRE: Funding continues to be inadequate to meet the needs in virtually all publicly funded treatment modalities throughout the State Agency's continuum of treatment services. As mentioned earlier, there are no specialized treatment services available for pregnant women. Treatment services for the dually diagnosed are limited to one specialized program covering the entire state. The availability of well qualified treatment staff is a major problem in all State-funded treatment facilities due in part to the fact that private providers are able to offer substantially higher salaries.

NEW JERSEY: Funds are needed to address the capital facilities/needs for expanded drug treatment facilities, for a combination of construction and/or renovation projects.

Increased funds are needed to fund treatment slots targeting intravenous drug abusers.

Funding is needed to provide extended care services for homeless/chronic debilitated alcoholics and other drug addicts.

Funds for development of a long-term aftercare network for women, especially pregnant women recovering from substance abuse, including prenatal care, home visits, ongoing counseling and nutritional support.

NEW MEXICO: The major needs are manpower and fiscal resources. Manpower for developing a comprehensive planning, program development,

and implementation of delivery care system; and fiscal resources to support the system.

NEW YORK (ALCOHOL): Services for the medically indigent: A large proportion of the population has inadequate or no health insurance for alcoholism services. Uninsured patients represent a burden for funded programs and might not be served by proprietary programs. A large population of inpatient rehabilitation programs are proprietary.

Youth-oriented continuum of services: The current treatment system does not adequately serve youth who are alcohol dependent. Developing such a system will be costly.

Vietnam Veterans: While Vietnam veterans do access the alcoholism treatment system, there is a need for adequately trained staff to deal with post traumatic stress syndrome and alcoholism.

Pregnant Women: Programs need technical assistance in developing policies and procedures to serve pregnant women with alcohol problems. Pregnant women need information and awareness campaigns to understand the dangers of alcohol consumption and seek appropriate health services.

Culturally sensitive treatment alternatives: The major resource needed is adequately trained staff.

Community residence development: The major resource needed is local cooperation in obtaining sites.

NEW YORK (DRUG): New York State is faced with an epidemic of drug and alcohol abuse which threatens the well being of the entire State. Although New York has developed the largest organized system of care in the nation, with a capacity of nearly 50,000 individuals in publicly funded programs, a major program of expansion is needed. This expansion will require new facilities across the State, as well as a major effort to recruit and train staff.

Among the special populations requiring priority attention, we would identify: (1) pregnant substance abusing women, (2) children of substance abusers, (3) AIDS victims, (4) the homeless, and (5) the criminal justice population.

NORTH CAROLINA: North Carolina needs increased financial resources to build new facilities, upgrade old ones, to provide new/additional services to homeless, high-risk youth, substance-using women, minorities and other special populations. We need additional staff, who will require training in reaching special populations and in technologies with which they are not familiar. We need to implement new technologies to improve service delivery in all our programs.

NORTH DAKOTA: Shortage of licensed addiction counselors in both public and private sector.

Services for the dually diagnosed is still a need and public sector is unable to meet this population need.

Training for public and private providers in the area of AIDS.

OHIO: There are two major needs identified in Ohio for which resources are inadequate. There is a need for residential rehabilitation. Providing these services will require increased funding. The funds will be used to increase the number of qualified and trained staff, facilities, training and those services which have been determined as critical to these types of clients, i.e., increased medical problems, aging populations and other special populations.

Ohio has received funding for an AIDS consultant from a grant provided to the Ohio Department of Health. This individual will need assistance in providing training to methadone and non-methadone sites in Ohio.

An additional major need is for the purpose of evaluating treatment and prevention services. Training and funds will be required to seek answers to the following questions:

Are current activities delaying a rise in use among the youth?

Are current activities preventing use among the youth?

Has current programming reduced the numbers of new substance abusers?

OKLAHOMA: Major needs are expanded treatment for women with children, pregnant women, and women and infants. Other major needs include services for mentally ill/chemically dependent, case management, and a strengthened outpatient network. Training continues to be a critical need. Staff and funds are more needed than are additional facilities.

OREGON: Treatment funds are needed for special populations, i.e., addicted women, adolescents, ethnics of color, correctional clients, dual diagnosis clients, hearing impaired clients.

Additional funds are needed to stabilize the State prevention system.

Research is needed to improve upon treatment outcomes.

PENNSYLVANIA: Addicted pregnant women services.

Addicted women with children services.

Adolescent assessment and treatment services.

Case management services.

PUERTO RICO: Additional funding for establishing residential treatment for women, girls and for expansion of residential treatment for male adults.

Detox and treatment facilities for homeless addicts and for AIDS diagnosed addicts.

Outreach staff for shooting gallery addicts.

Major outreach with the female alcoholic population is needed to get them in treatment at an early stage of their alcoholism disease.

Additional treatment centers for alcoholism are needed in certain geographical areas, where a high incidence of alcoholism problems have been identified. Examples of these are: hospitalization unit in Ponce and an outpatient center in Guayama and Fajardo.

RHODE ISLAND: Residential program serving women with their children (capital and operating dollars).

Coordination of services for pregnant women - training; printed information for staffs; public service announcements (PSAs) and other materials for the public.

Funding for mobile treatment team and other dually diagnosed clients; closure on who has responsibility: mental health or substance abuse; ability to tap other appropriate resources.

SOUTH CAROLINA: The State's top treatment priority is programs and services for adolescents, to include one inpatient treatment facility, one halfway house, nine intensive outpatient programs and additional adolescent counseling specialists. Priorities for adult treatment services include expansion of detoxification (non-hospital services), development of 13 new intensive outpatient programs, and provision of residential treatment services for women. Improvements in information and data processing technology are sorely needed at the local agency level.

SOUTH DAKOTA: Providing adequate services in sparsely populated areas, especially Indian reservations, remains problematic. A Federal clearinghouse which could provide the States with clear information on substance abuse funding to reservations, tribes, Indian Health Service, etc. would be most helpful in developing mutual planning to serve this population.

TENNESSEE: Major Needs for Treatment:

In our State an increase in all types of treatment services is needed. This includes all the traditional treatment services

(outpatient, detoxification, residential rehabilitation, halfway house, etc.) targeted to both adults and adolescents.

New program focus would include the following types of services: therapeutic community, juvenile justice, regional wilderness programs for kids, intensive outpatient, adolescent day treatment and group homes.

Services for special populations would be targeted to homeless, dual diagnosed and families of alcohol and drug dependent persons.

Upgrading existing alcohol and drug facilities and expansion of these same facilities and construction of brand new facilities is of real importance.

Resources reserved to provide the above alcohol and drug activities would require major increases in both State and Federal support.

Major Needs for Prevention:

An across the board increase in all types of prevention programs and activities. This includes the following program/activities: information/evaluation, media campaign, family intervention, teacher training, teen institute, early intervention, youth alcohol safety programs, innovative prevention grants, parents groups, community prevention networks, and regional prevention coordination.

Prevention Evaluation - Evaluation of existing prevention programs and activities (i.e., outcomes and impacts of programs/activities).

TEXAS:

Alternative and less costly training delivery systems, such as correspondence courses, teleconferencing, computer conferencing, etc. The Addiction Research Foundation in Ontario has an interesting "distance education" model worth exploring. Need more services for adolescents, families of IV drug users, high-risk youth, etc.

UTAH: For the past four years the Division has set as its major priority the need for increased funding of youth early intervention and treatment services. About 13,500 youth are in need of treatment. About 52,000 regular teen drug users are in need of intervention. We currently treat about 1,100 youth per year.

VERMONT: The State supported treatment system needs the training and technology which would enable it to apply treatment routines which would move clients toward the accomplishment of specific treatment objectives in specified timeframes and delivered in the context of the clients' total environment. Such a system would rely more heavily on treating clients in groups and in more intensive regimens.

VIRGINIA: Housing, employment counseling, additional community staff focusing on special populations, research on treatment outcomes and matching types of clients with types of treatment, health care for indigent persons who abuse substances and additional community detoxification capacity.

WASHINGTON: Involuntary commitment for drug addicts: Our law allows for detoxification and involuntary detention of alcoholics and drug addicts, and for involuntary commitment/treatment of alcoholics, but does not allow for involuntary commitment of drug addicts. PROBLEM: funding for the commitment process (administrative and legal) and for the involuntary treatment. Requires a stronger medical component.

Special treatment for alcoholics/addicts with unrelated mental problems: Requires special treatment programs and staff to work with both problems simultaneously. Must be greater than the sum of the parts. PROBLEM: funding for the treatment/mental health services, and training for special staff.

WEST VIRGINIA: The major needs for the State are a direct result of lack of financial resources. For instance, lack of competitive salaries hinders the recruitment of qualified staff.

All service components need expansion. In particular there is a need for: (1) Additional day treatment programs for adolescents, (2) Additional residential treatment units for adolescents to facilitate family involvement and aftercare, (3) An expansion of long-term treatment for chronic abusers, (4) "Holding" units for persons court-committed for treatment but awaiting placement, (5) Sufficient staff to provide appropriate outpatient care, including outreach and early identification, and (6) Funds to pay for medical detoxification for indigents.

WISCONSIN:

Funding resources are needed for improved services to youth, and to other underserved populations including minorities, women, the physically disabled, sensory impaired, IV drug abusers and AIDS program, cocaine babies and pregnant women in need of treatment.

APPENDIX E

STATE NARRATIVE REPORTS OF SIGNIFICANT CHANGES IN SERVICES DURING FISCAL YEAR 1989

STATE NARRATIVE REPORTS ON SIGNIFICANT CHANGES IN SERVICES DURING FISCAL YEAR 1989

ALABAMA:

- Providers report a rise in crack/cocaine addicted admissions, decline in age of population served - particularly in halfway houses. Opened first intensive outpatient and residential combined programs aimed at pregnant women. Bond issue funds for construction of adult and adolescent facilities were made available.

ALASKA:

- Increased emphasis has been placed on children of alcoholics, AIDS, fetal alcohol (and cocaine) syndrome, and inhalants, as training, prevention, and treatment issues.

ARIZONA:

- Growth in drug abuse clients treated in FY 89, as well as overall increases in ethnic populations served.
- Major shift to early intervention programs for high risk youth.

ARKANSAS:

- No major changes although major changes/additions are projected during the next fiscal year.

CALIFORNIA:

DRUG PROGRAMS DIVISION

- The Federal women's set-aside has been increased from 5 to 10 percent to provide additional alcohol recovery and drug treatment services to women and their children.
- The Federal law requires that at least 50 percent of the drug's share of the total Alcohol and Drug Abuse and Mental Health Services block grant dollars be spent on services to intravenous drug users.
- The Department of Alcohol and Drug Programs, in collaboration with the Departments of Health Services and Social Services, is currently implementing the first year

of a three-year pilot project. The pilot project will provide prenatal health care, alcohol recovery and drug treatment services, social services, and other supportive services to pregnant or parenting women and their children.

- The Department of Alcohol and Drug Programs is participating in the Federal Drug Abuse Treatment Waiting List Reduction Grant Program. This program will expand needed drug abuse treatment capacity.

ALCOHOL PROGRAMS DIVISION

- In August 1989, the Department undertook a major reorganization which included the prevention function. This reorganization was to combine the drug and alcohol prevention and program development activities into a single branch with the following sections: Program Assistance, Policy and Program Development, Youth Prevention Services, Intervention and Recovery Services.

- Added program (pilot) of children of alcoholics as this may be highest risk and highest need population.

- Added program (pilot) for women who are pregnant or post partum and their children.

- Legislation enacted in 1989 provided for the expansion of services provided to the repeat DUI offender. The program is expanded from 12 months to 18 months. Legislation was also enacted to mandate State licensure of first-offender drinking driver programs.

COLORADO:

- Have dedicated more publicly funded beds to treat adolescents.

- Have developed new AIDS regulations and associated training programs.

- New program funding available through new OSAP direct grant programs

- Repeat DUI offenders need more specialized and intense treatment.

- Development of offender residential treatment, TASC programs for paroles, pre release program and changes in corrections diagnostic center to improve detection of substance abuse problems.

CONNECTICUT:

Intervention Activities

- Victim Impact Panel (VIPs): Addition on a pilot basis of VIP developed by MADD as a component of the State Agency funded pretrial alcohol education system program.

- Expansion continues in the area of AIDS education, testing and counseling programs in treatment sites, staff training on AIDS issues and AIDS risk reduction outreach worker programs.

Prevention Activities

- YES program of Regional Youth Substance Abuse Program (RYSAP) (Contact John Higgins-Biddle through Clifford Laube).

- School Survey of grades 6 - 12 was conducted to determine the incidence and prevalence of use and abuse of alcohol and other drugs; over 16,000 students participated. The results of the study will be available in early 1990. (Contact Clifford Laube)

Planned and Funding Activities

- Governor's Partnership on Prevention of Substance Abuse in The Workplace "Drugs Don't Work" is a Statewide public/private partnership (primary and secondary schools, higher education and workplace).

- A Regional Action Councils initiative is a public/private partnerships comprised of area leaders. Its purpose is to establish and implement an action plan to develop and coordinate needed services in the field of substance abuse (Contact Clifford Laube).

- P.A. 89-390 added $7.6 million of annualized funding for expansion of substance abuse treatment capacity throughout the State.

- The Connecticut Alcohol and Drug Abuse Commission (CADAC) was one of six State of Connecticut agencies to receive additional funding from the State to augment non-profit grantee funding levels in order to increase salaries and fringe benefits for direct service and support personnel. A State survey revealed inadequate staffing levels in many programs (particularly the 24-hour facilities), high staff turnover and recruitment problems because of

inadequate salaries to employees in the human services field. CADAC received $1.4 million for this purpose in FY 88 and $1.1 million in FY 89.

Changes in Legislation

- P.A. 89-390 (Section 1-11): Changes commitment to court order referral; treats alcohol and other drugs equally; requires evaluation by State agency for placement.

- P.A. 89-390 (Other Sections): Additional funds for substance abuse programming or related programming in a very lean year.

- P.A. 89-314: An act concerning administrative per se license suspensions takes effect on 1/1/90.

DELAWARE:

- In order to counteract the shortage of residential treatment slots and the gaps in the overall system's continuity of care, we are developing a network of intensive outpatient, case management and continuous treatment teams to address the needs of the chronic and high-risk substance abusing populations.

DISTRICT OF COLUMBIA:

- Increased attention to law enforcement and the appointment of a Drug Czar.

Drug Abuse Trends:

- Drug abuse in the District of Columbia has begun to show some strong and consistent signs of decline. Almost all of the current indicators support this conclusion. Most of the decline started in the last quarter of 1988.

- Cocaine continues to be the drug of choice among illicit drug users. Crack cocaine has dramatically changed the market in terms of consumers who are participating in drug use behavior and the number of young people who are participating in the sale and possession of crack cocaine.

- In FY 1989, the District of Columbia recorded an unprecedented 467 drug related overdose deaths.

- Juvenile drug related arrests have increased 57% over 1988.

- Since the third quarter of 1988, alcohol-in-combination with other drugs, cocaine, heroin, and marijuana have all shown constant decreases.

- Over the last several months the District of Columbia has instituted a wide range of initiatives to reduce the magnitude of the drug problem. Proposals have included hiring more policemen; establishing a curfew for teenagers; arming police with 9 MM semi-automatic pistols; reassigning more police beats; establishment of temporary Drug Free Zones; using cement and blocks to board up vacant apartment and houses; and using Federal prisons to relieve crowded conditions at the City's correctional facilities.

  Some promising strategies have included:

  - direct admission to treatment - bypassing central intake

  - ward mobilization meetings - empowering block organizations and training community leaders

  - collaborating activities with private sector businesses and churches.

- The percentage of IV-related AIDS cases for various transmission categories appears to be stable.

FLORIDA:

- A single rule and regulation for substance abuse services, Chapter 10E-16, was adopted August 7, 1989, replacing separate regulations for alcohol and other drug abuse services.

- The Employee Assistance Program received a major boost via the enactment of a new law. The Drug Free Workplace Act, Chapter 112.0455, F.S., provides for drug testing of State employees and referral to the EAP when identified.

- The three successful Alcohol and Drug Abuse Indigent Health Care Demonstration Projects had to be terminated early due to a lack of funding. Funds were used instead for the Medicaid deficit.

- Cooperative efforts have been initiated between the Health Offices and the Alcohol and Drug Abuse Programs throughout the State for education and services for people with AIDS and/or who are HIV positive. A concentrated effort by both to work together has resulted in the change.

GEORGIA:

- The proliferation of crack/cocaine in rural areas of our State has increased the need for available treatment slots in these areas. There have also been increases in need for adolescent treatment slots and more attention focused on crack affected babies.

GUAM:

- With the discontinuance of the methadone treatment program within the Department of Mental Health and Substance Abuse several years ago, there has been a significant decrease in the number of clients seen for drug treatment services. Conversely, the utilization rate for alcohol treatment services has been slightly increasing because of the program's revitalization in late 1988.

- Additionally there has been an increase in the number of collateral clients requesting information and seeking treatment from the Department of Mental Health and Substance Abuse, Drug and Alcohol Branch.

HAWAII:

- Growing use of crystal methamphetamine began to impact regional perinatal centers, mental health treatment programs and substance abuse treatment programs.

- Corrections Department received a Federal Grant for substance abuse treatment planning for the prison population.

IDAHO:

- Due to the large increase in school response to the alcohol-drug abuse problem, i.e., early identification of youth with problems, there has been a correspondingly large increase in referrals to treatment.

ILLINOIS:

- The Drug Free Illinois Initiative will enable Illinois to make tremendous strides in treatment and prevention services, particularly in areas such as:

  - Services for women

  - Services for youth

- Services for intravenous drug users
- Criminal justice services
- Special projects

o Service capacity increases which were initiated late in FY 89 will continue impacting both the quantity and quality of services well into the 1990s.

INDIANA:

o Establishment of a "Commission for Drug Free Indiana" - to expand efforts of developing a more integrated approach to prevention services

o Expansion of services for women

o Legislation to allow one-time tax credit for costs associated with alcohol and drug component of EAP programs.

IOWA:

o Large waiting list - as of October 5, 1989, 1,416 clients waiting for admissions to treatment programs.

KANSAS:

o Addition of seven continuing care counselors.

o Population being served is decreasing in age. Alcohol and drug problems are being identified at an earlier age. While there has been a decrease in admissions for alcohol problems, there has been an increase in admissions for other drug problems. Overall, admissions are increasing.

KENTUCKY:

o Driving Under the Influence (DUI) program transferred to the Division of Substance Abuse from the Department of Transportation; increased demand for adolescent treatment (chemically dependent and emotionally disturbed); and implementation of group home loan program.

LOUISIANA:

o Adolescent Assessment: A statewide training effort was conducted in 1989 with over 70 clinicians to employ a standardized assessment protocol to be used with adolescents.

- Adolescent Treatment: Louisiana has dedicated significant resources to adolescent residential and halfway house treatment services. One new residential facility and two new halfway houses were opened in 1989 with a third to open in the Spring of 1990. This effort coordinates an increasing sensitivity in our school environment of treatment of dysfunctional children with trained assessment potential in our outpatient clinics with new bedspace to treat them.

- AIDS: The Division of Alcohol and Drug Abuse has joined with the Office of Public Health to fund community-based positions to provide AIDS education and counseling to persons in need in the alcohol and drug abuse system.

- Criminal Justice: The Division of Alcohol and Drug Abuse has established preliminary agreements to develop and fund a pilot project to treat selected inmates in a pre-release, therapeutic community environment. Project is to commence in the Spring of 1990.

MAINE:

- Assignment of responsibility to approve EAPs for companies wanting to test for drugs

- Recent allocation of dollars has been for maintenance of effort - replacement of lost funding from other sources. We are seeing our purchasing ability melt away, with flat Federal and State funding.

MARYLAND:

- Continued merger of categorical alcohol and drug abuse treatment programs into substance abuse programs.

- Increase in outreach and services to pregnant abusers and other special populations e.g., adolescents, hearing impaired.

- Implementation of non hospital residential detoxification services program.

- Implementation of a demonstration methadone-to-abstinence treatment program.

MASSACHUSETTS:

- Medicaid began to pay for methadone and residential detoxification services.

- Admissions for cocaine treatment continue to increase.

MICHIGAN:

- No significant changes in service delivery, but there has been an increase in the use of crack cocaine and the number of drug exposed infants born in Michigan.

MINNESOTA:

- 1989 Drug Bill

MISSISSIPPI:

- Because of the increase in cocaine and other drug use in the State, drug beds and drug counselors have been added to traditional alcohol residential facilities.

- Because of increased penalties for DUI convictions, treatment programs have modified their outpatient services to give specific treatment episodes (e.g., 15-week intensive outpatient).

MISSOURI:

- A significant expansion in IV-drug treatment programming in both St. Louis and Kansas City was initiated. Prevention programming, adolescent treatment, and women's treatment services were expanded. Cocaine use, especially crack, has exploded from 164 cases in FY 83 to 3,570 in FY 89. In FY 89, cocaine became the second most commonly abused drug after alcohol in Missouri.

MONTANA:

- Increase in number of people who wish to become certified counselors due to third party payments for outpatient counseling by private practitioners and push by Indian Health Services to have all Native American programs use certified staff only.

- DUI legislation requires all second and subsequent offenders to be admitted to treatment. In addition, only certified counselors can do assessments.

- Improved documentation and tracking on clients admitted to treatment with primary problems of drugs other than alcohol and IV drug use via new recording requirements and State priorities. Correspondingly, a significant increase in clients admitted in these categories.

- Increased emphasis on intensive outpatient programs.

- Increase in voluntary prevention groups in rural Montana.
- Increase in funding mini-grants due to CYAP targeting parents and better networking.
- Continued increase in prevention activities and interest throughout Montana.

NEBRASKA:

- There have not been significant changes during the past year.

NEVADA:

- In FY 89 the Bureau began funding a new service. We began funding a transitional program for women which allows women's children to stay with them in the program.

NEW HAMPSHIRE:

- The State Agency has discontinued it's scattered site detoxification program for lack of funding. It is expected that one 28 day residential program will be expanding in a new location as a result of obtaining HUD homeless grant monies and a new residential facility will be opening in 1990 utilizing in part, HUD funds. The State Agency will be working with and providing substantial funding to set up a prison halfway house for substance abusing inmates.
- The State Agency has also greatly expanded prevention efforts in the areas of student assistance programs, piloting parenting as prevention trainings, and a community youth activities project.

NEW JERSEY:

- The 1989 ADMS Block Grant Award mandated that $3.1 million be allocated for specialized services for indigent women, especially pregnant women. These funds were used to expand and implement services for critical needs which have been identified in the last two years including: (1) case finding in perinatal centers; (2) educating health professionals about FAS; (3) purchase at a rate established through a rate setting methodology of 28 day residential stays from licensed facilities; and (4) implementation of halfway house and shelter services for women with dependent children.

NEW MEXICO:

- Increase in substance abuse prevention activity due to additional revenues available to States.
- Increase in services to adolescents due to better identification and referral system, and expansion of services to this population.
- Increase in number of women receiving services.

NEW YORK:

ALCOHOL PROGRAMS DIVISION

- Impact of AIDS: The Division has been providing training to local program staff to prepare them to respond appropriately as the prevalence of AIDS and HIV-infection among alcohol patients increases. The treatment of persons with AIDS will require additional program resources to provide patient education and special support services.
- Omnibus Criminal Justice Bill: Parts of this NY law which was recently passed require an increase in the alcohol and drug treatment services provided to inmates, parolees and probationers.
- Anti-Drug Abuse Council: Governor Cuomo convened this council, which includes the Division of Alcoholism and Alcohol Abuse, the Division of Substance Abuse Services, the Department of Health, the State Education Department and various State criminal justice agencies, to develop and coordinate innovative approaches for enforcement, prevention and treatment.

NEW YORK:

DRUG PROGRAMS DIVISION

- The major developments during FY 89 included: The tremendous growth in the number of substance abusers with AIDS and HIV infection; the increasing numbers of poly-addicted individuals with a wide range of psychological and social dysfunctions; the increasingly strong connection between substance abuse and homelessness; the growing links between crime and substance abuse; and the emergence of profoundly increased drug abuse among women of child bearing age. These developments have required treatment and prevention programs to adjust to the special challenges of this increasing complex environment.

NORTH CAROLINA:

- Statewide implementation of DWI assessment programs. Possibly 30,000 - 40,000 new clients annually.
- Increasing arrests of persons on illicit drug charges.
- Prison/Correction overcrowding.

NORTH DAKOTA:

- Prevention: The North Dakota Prevention Resource Center has been in operation for one year. It offers library services of print, video and curriculum materials; a clearinghouse of pamphlets, booklets, posters, brochures, stickers, and technical assistance for the development of prevention programs in schools and communities. All materials are available without charge to all persons in North Dakota.
- Efforts are progressing in developing a network of prevention programs and people throughout the State. The first Statewide Prevention Conference was held in October, 1989; training of trainers for two parenting in prevention programs will occur in early 1990; and a quarterly newsletter is an early efforts at facilitating some grassroots networking for alcohol and drug abuse prevention activities.
- Coordination: Governor Sinner has issued an Executive Order creating the Policy and Planning Commission for Alcohol and Other Drug Abuse Prevention. The Commission consists of representatives of State agencies involved in prevention efforts, two State legislators, a representative of the Governor's office and two citizens-at-large (one of whom is a youth). The principle goals of the Commission are to develop common language; to determine all existing programs and resources; and to develop a comprehensive plan to coordinate efforts and to reduce duplication of gaps in programs and services to the State.
- Treatment: The 1989 State Legislature has mandated a reduction in the number of admissions to the North Dakota State Hospital Chemical Dependency Unit and the development of regional community based services. Funding was made available to each of the eight (8) regional human services centers to further expand the

continuum of care so persons can be more efficiently served closer to home. Specifically, the new services will include:

1. social detoxification, a safe supportive environment in which an individual may be withdrawn from chemicals of abuse;

2. emergency medical services, providing medical detoxification for those whose condition warrants it;

3. day treatment services, providing intensive day long treatment close to the client's home or community;

4. short term residential care, basically designed to provide room and board to clients in day treatment programming who live in towns too distant to make a daily trip; and

5. long term residential care, designed to provide long term support and a sober environment, particularly to the client who is exceedingly relapse-prone or who has high habilitative needs which may interfere with recovery. The very rural nature of North Dakota coupled with long driving distances to obtain services make a regional approach to these services most practical, at least initially.

OHIO:

- On October 10, 1988 legislation signed by Governor Richard F. Celeste created a new Ohio State Department of Alcohol and Drug Addiction Services. This Department resulted from the combining of the Bureau of Drug Abuse, which had been in the Department of Mental Health, with the Bureau on Alcohol Abuse and Alcoholism Recovery, which had been located in the Ohio Department of Health. The new Department will: develop and administer a Statewide plan for alcohol and drug services; establish guidelines for the use of State and federal funds; and develop measures for increasing the accountability of alcohol and drug service programs. The creation of a single planning, funding and monitoring authority at the State and local level will also strengthen Ohio's emphasis on the special needs of minorities, women, children/adolescents, and people in the criminal justice system.

The same legislation that created the new Department also created an advisory body, the Council on Alcohol and Drug Addiction Services. This organization will function as an advisory body to the Director of the Department of Alcohol and Drug Addiction Services. In addition, the Council will evaluate Ohio's drug and alcohol services system and subsequently make recommendations to the Governor and to the Legislature.

The new middle management will be fifty-three Community boards. Forty-six boards will be combined Boards of Alcohol, Drug Addiction and Mental Health Services. Seven of the ten counties with the largest populations exercised the option open to them of creating a new Board of Alcohol and Drug Addiction Services and retaining the existing Mental Health Board. Three created a new combined board of Alcohol, Drug Addiction and Mental Health Services. The twelve Regional Councils on Alcoholism will be eliminated and all Boards will have additional membership requirements to reflect alcohol and drug interests.

The State of Ohio has developed a cluster of 24 State agencies who are preparing a plan which will allow them to pool their resources and knowledge in order to address the identified problems encountered by each agency, prioritize them and work together towards implementation in order to change events in Ohio.

There is a constant need to develop qualified staff who will remain in the system. This will tax the treatment and prevention funds for salaries training and other needs resources.

The management information staff is in the process of selecting a company to develop the newly established data requirements into the existing system and to add new requirements as trends are noted. Because of the lack of an in-depth management information system, we cannot access information that would provide drug use trends. Ohio is able to provide information which indicates driving under the influence convictions are continuing to rise over the past five-years with miniscule changes in recidivision.

Ohio has the services of an AIDS consultant who is in the process of coordinating requirements in identification of HIV positive persons, pre and post counseling, partner notification, mantoux testing and outreach for HIV counselors housed in the nine methadone clinics in Ohio.

Finally, the Governor called for a Drug Summit in early November where over 600 participants, volunteers, professionals in the field of substance abuse, community leaders, law enforcement, politicians and other interested individuals met, identified needs and discussed how those needs could be implemented. The Governor has requested the development of a Drug Summit for Youth. The Department is currently taking the lead in this process.

OKLAHOMA:

- Adolescent services have been significantly increased, as has awareness, training, and treatment in AIDS and for the mentally ill/chemical dependent. More (approximately 10 per month) addicted babies are being born - no specialized programs exist for mothers.

OREGON:

- 8,000 families have been trained to reduce high risk factors for early onset of alcohol and drug problems (10 hours of training).
- Prevention/intervention and adolescent treatment capacity are now available in every county in the State.
- Pilot projects in public housing units have been initiated.

PENNSYLVANIA:

- Act 152 of 1988 enabled State Medicaid funds to be available for residential non-hospital treatment services for the first time. Several sites are being selected to institute implementation of this program. This effort will have a significant impact on the increased availability of drug and alcohol treatment services to the indigent.

PUERTO RICO:

- Prevention services and educational campaigns have expanded. Two new prevention centers were opened in Catano and Utuado. This has been possible with additional funding.
- Detoxification and treatment with acupunture and psychosocial treatment has been incorporated into our regular program in four (4) locations.
- Treatment services have been expanded.

RHODE ISLAND:

- State consideration of establishing a new higher level Department of Substance Abuse (SA) - significant increase in interest in substance abuse - enforcement vs. treatment issue; Adolescent services - residential; day treatment - Talbot

- Beginning of coordination efforts - pregnant women (began out of interest in OSAP grant - being led by Speaker of House's Office as standing working group).

- Expansion of methadone services.

SOUTH CAROLINA:

- Four demonstration prevention projects have been established targeting high risk urban youth. An alcohol and drug abuse treatment unit has been opened at the Department of Corrections with aftercare in county alcohol/drug agencies built in as a condition of parole. Public sector inpatient treatment capacity for voluntary patients has been severely eroded as a consequence of rapid increase in the numbers of persons entering treatment under the State's involuntary commitment statute.

SOUTH DAKOTA:

- Four intensive structural adolescent outpatient treatment programs were initiated.

- State accredited treatment programs were initiated within each of the State's adult correctional facilities.

- A lack of certified chemical dependency counselors is harshly limiting the ability of the treatment system to expand to meet the demand for treatment services.

TENNESSEE:

- A number of treatment and prevention programs received one-time block grant dollars for provision of alcohol and drug services. Recurring prevention block grant dollars resulted in the creation of new early intervention and other prevention programs.

- The Drug Free Youth Act which serves as a deterrent for kids (13-17) not to use alcohol and drugs, will revoke driver licenses for non-compliance.

TEXAS:

- The State legislature appropriated additional funds for services for children and youth.
- The State legislature reformed the criminal justice system and included funds for substance abuse treatment.
- Crack and cocaine are continuing to increase in addition to amphetamines.

UTAH:

- Treatment services to youth have increased 46% between FY 88 and FY 89, due to the increased focus of State and local funding priorities. Teen 30 day use rates have dropped in 12 of 13 drug categories from 1984 to 1989. Cigarettes showed modest increases. The most dramatic decline was in 30 day marijuana usage which plummeted from 12.2%, in 1984 to 6.1% in 1989. Adult drug use results were mixed. The most frequently used drugs (alcohol, tobacco, marijuana, analgesics and cocaine) were down in 30 day use. Tranquilizers, amphetamines, hallucinogens, barbiturates and heroin use was up between 1983 and 1989. The primary drug users are males ages 18-25. We believe six years of state-of-the-art prevention projects are working to reduce teen drug use.

VERMONT:

- Protocols for AIDS education were established for people entering treatment.
- Perinatal education required for all women of child bearing age entering treatment.
- Funding changes provide incentives for shorter lengths of stay in residential treatment.
- Three new intensive outpatient treatment programs were funded prior to the close of FY 89.
- Three new Oxford House recovery homes were opened in Burlington.
- Mandatory treatment screening for all DWI offenders was passed by State legislature.
- Number of cocaine abusers in treatment increased by 95% from FY 87 to FY 89.

VIRGINIA:

- Adolescent services - hired an additional staff person who specializes in this area.
- AIDS - developed a staff position to specialize in AIDS issues and enhance community awareness on the issues.
- Criminal Justice Issues - legislative focus on substance abuse services and criminal justice services interaction.
- Impact on funding provisions - increased federal accountability requirements.
- New State legislation - youth under 18 years of age can lose their driving privileges if convicted of a drug/alcohol offense.
- A significant increase in the numbers of substance exposed infants.

WASHINGTON:

- The State has continued to implement the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), providing alcohol and drug treatment, and/or shelter to indigent alcoholics and addicts. Implementation was impacted by court rulings which challenged legislative intent regarding required residence in a State contracted shelter facility, and in the criteria the State employed in restricting services to persons because of the limited funding level. Two amendments to the Act have resulted in more restrictive eligibility criteria for ADATSA shelter, effective July 1, 1989. The ADATSA treatment portion of the program has not changed. Treatment funding is continuing for FY 1990, but at lower than the demand-level shown in FY 1988. FY 1988 funding for treatment was also below the subsequent demand level.

WEST VIRGINIA:

- No significant service changes.

WISCONSIN:

- Increased training for counselors in IV-Drug Abuse and AIDS

- The development of pilot programs, including treatment alternative programs; hearing impaired pilot; women's treatment pilot; juvenile justice pilot, minority pilots, etc.

- There has been increased emphasis on certification of minority counselors.

- Signing of an interagency agreement for processing and providing treatment.

- Implementation of the "Alliance for a Drug-Free Wisconsin."

- Increased technical assistance on drug free workplace program development.

APPENDIX F

STATE NARRATIVE REPORTS ON ISSUES AND CONCERNS RELATING TO MEASUREMENT OF ACCESS TO APPROPRIATE CARE/WAITING LISTS/ CONTINUUM OF CARE SERVICES

ISSUES AND CONCERNS RELATING TO MEASUREMENT OF ACCESS TO APPROPRIATE CARE/WAITING LISTS/ CONTINUUM OF CARE SERVICES

ALABAMA:

- Major Issue: Lack of accurate information regarding waiting lists; those applying for services versus those admitted and distribution of service demand.
- Second Issue: Availability of appropriate continuum of care.

ALASKA:

- Very low population with limited highway system limits ability to match clients with appropriate treatment and provides unusual problems in the provision of family and aftercare services. Waiting lists, particularly for clients referred by the criminal justice system, are quite lengthy.

ARKANSAS:

- Over 90% of residential, state-funded treatment facilities have waiting lists in excess of 5 days. Women's residential treatment services in metropolitan areas have waiting lists greater than 10 days.

CALIFORNIA:

- A provision of the Comprehensive Alcohol Abuse, Drug Abuse, and Mental Health Amendments Act of 1988 requires that programs providing treatment for IV drug abuse notify the State upon reaching 90 percent capacity. This will help to ensure that individuals requesting IV drug use treatment, to the maximum extent practicable, be admitted into treatment within seven days after making the initial request.
- The Department of Alcohol and Drug Programs (ADP) is participating in the federal Drug Abuse Treatment Waiting List Reduction Grant Program. The intent of this program is to reduce waiting lists in drug abuse treatment programs. The waiting list data will assist ADP, the counties, and individual treatment providers to: 1) optimally use existing treatment services; and 2) coordinate treatment resources to match community needs.

COLORADO:

- Private pay programs are redirecting revenues from publicly supported programs creating a dual system and increasing the problem severity of those clients served by publicly supported programs.
- The term "waiting list" is not easily defined for the continuum and is a poor measure of need.
- In rural areas there is a definite need, but low volume and transportation requirements lead to higher costs for services. Because of small numbers, much more therapy is given in individual sessions rather than groups, adding to the increased costs. Rural programs are not as cost efficient as urban ones, yet most funding bodies want to pay the same rates.
- Additional costs are necessary to provide adequate services for the physically handicapped, blind, deaf, and bilingual. Therefore these services cannot be provided at the average cost.
- Similarly, dually diagnosed clients require additional services and staff with more extensive training and experience. This adds to cost.
- The Criminal Justice system is oriented toward developing its own treatment system rather than utilizing existing resources.

CONNECTICUT:

- Lack of an incidence and prevalence study.
- Lack of beds and outpatient slots.
- Lack of a automated waiting list data.
- Lack of unique client identifier.

DELAWARE:

- We are now closely monitoring waiting lists at all treatment agencies to assess shifts, trends, etc.

DISTRICT OF COLUMBIA:

- The need for case management personnel, coordination of existing services and the lack of aftercare (relapse prevention, etc.) are major issues for the continuum of services and access to services in the District of Columbia.

- Also, data collection capability is a major issue in the measurement of access to services in the District. The current data system:

  1. targets only public treatment admissions, and

  2. is primarily a manual data collection and storage system with limited data analysis and projection capability.

- Financial resources are necessary to address data management needs. A regional data collection initiative is probably the most cost effective.

FLORIDA:

- In addition to waiting lists information provided, current issues and concerns include lack of capacity, child care, transportation, data accuracy and issues related to insurance. Ethnic barriers may also be an issue.

GEORGIA:

- Waiting list validation is a problem. Typically alcohol and other drug clients do not "wait". Follow-up is almost futile for certain treatment populations.

HAWAII:

- Hawaii is missing some components of a continuum of care particularly on the neighbor islands. Other problems include: (1) Difficulty of ascertaining valid waiting lists; and (2) Growing issue of treatment on demand for IVDU/AIDS.

IDAHO:

- Measurement of access to appropriate care - currently, there is no measurement or index of the problem levels of persons needing treatment, so a determination of whether or not they are able to access appropriate care cannot be made. In other words, we don't know what is out there, we only know about who is knocking on the door. We don't know about people who have accessed treatment and not received it, or not followed through and for whatever reasons.

ILLINOIS:

- There are currently large gaps in the treatment system, both in its ability to serve additional clients and its capacity to provide a continuum of services of the varied intensity necessary to meet the needs of the current treatment population. This demand has served to inappropriately decrease lengths of stay for some while creating intermittent treatment cycles for others. Development of additional services within a balanced services system will require clearer definition of need methodologies, program descriptions, client outcome measures, effective procedures for local needs assessment, referral, utilization review, discharge planning and program evaluation procedures.

INDIANA:

- Criteria for Federal "Waiting List" funds favors larger population areas, favors outpatient services, and favors those States which will receive an increase in ADMS block grant funds and will thus have more dollars available to continue programs.

IOWA:

- Concern on appropriateness of care in a rural environment and trying to treat people as close to home as possible.

KANSAS:

- It is difficult to maintain "clean" waiting lists - some clients are on multiple program lists and clients are not on any list because "they don't want to wait". In a rural setting it is tougher to maintain waiting lists as number of programs is small, all have some people on list. Also, it is difficult to match clients to services when all services are overwhelmed.

KENTUCKY:

- Problems exist in defining outpatient capacity statewide (individual and group services are available in many communities and that complicates capacity estimates).

LOUISIANA:

- Most programs do not maintain active waiting lists for services. Clients unable to access one program may be referred, or may continue to seek alternate programs.

Those maintaining waiting lists find many patients "lost to contact" when called for admission. The maintenance of waiting lists becomes labor-intensive, is often a futile effort, and the lists are virtually meaningless.

- IV drug set-asides are a problem. A growing population presenting for treatment includes poly-drug abusers in the young (25-35) working class (lower middle and/or upper lower). Targeting of block grant monies with specific percentages or dollar amounts potentially jeopardizes continued funding of "generic" treatment programs.

MAINE:

- Obtaining a complete picture is complicated by different definitions and, our purchase of services from only a part of system. However, having some information in this area - nationally and state-by-state is critical.

MARYLAND:

- In order to more accurately assess treatment demand, a waiting list policy was developed and implemented throughout the State funded treatment network. Each program maintains a current waiting list (if needed).

MASSACHUSETTS:

- Access to treatment is often a function of persistence, not simply waiting. A better reflection of demand might be requests for treatment that are denied because of no room. Appropriate care requires standards that match clients to services and measures of achievement to assess outcomes.

MICHIGAN:

- There is a lack of appropriate services in outpatient and residential settings for women, adolescents and women with children. Many of the individuals on waiting lists in Michigan are males requiring services in a residential setting. Many programs do not maintain formalized waiting lists, since the population that is often in need of services does not have a permanent address or phone. Methadone treatment slots are not available on a statewide basis.

MINNESOTA:

- The Consolidated Chemical Dependency Treatment Fund (CCDTF) virtually eliminated concerns around access to services. There are generally no waiting lists for treatment, except for methadone. There is sometimes a wait for assessment in the metro area, although data show that 75 percent of all public clients are assessed within one week. The issues that remain are primarily around the lack of treatment service providers that can provide bilingual/bicultural services to S.E. Asian and Hispanic populations. There is also a need for services that are appropriate for adolescents and chronic alcoholics.

MISSOURI:

- Consumers of the information (i.e., elected officials, government officials, decision makers, etc.) should be educated about the strengths and weaknesses of using waiting lists as a measure of demand for treatment. Additional measures of need for services should be developed and provided.

MONTANA:

- A shortage of State funds exists for inpatient treatment for indigent IV users. It is difficult to measure waiting lists accurately when clients can be on several waiting lists. 90 percent of capacity needs to be defined, i.e., 90 percent of funded beds or 90 percent of entire bed capacity. Treatment programs report inconsistently.

NEBRASKA:

- Problems include determining (evaluating) appropriate care for client needs; training evaluators; forming a full continuum of care for all areas of a rural State with trained, premium paid staff recruited to rural settings.

NEVADA:

- Waiting lists may be measured by length of wait for admission or by a count of people on a waiting list. The former method misses people who did not follow through with treatment due to the wait.

NEW HAMPSHIRE:

- All State Agency contracted facilities are required to monitor their waiting lists. These waiting lists are periodically monitored by the State. Waiting lists are typically four weeks for residential facilities and two to three weeks for outpatient services. Halfway house waiting lists vary from four to six weeks depending on the facility. Access to appropriate care is, of course, compromised due to the sometimes extensive waiting lists for particular facilities.

NEW JERSEY:

- Statewide utilization review criteria are issued to guide private third party payers regarding client access to the appropriate level of care for the needed length of stay.

NEW MEXICO:

- Programs do not maintain lists. They tend to overextend, consequently provide many services which are never reimbursed. When lists are maintained there is no consistency/uniformity in such lists.

NEW YORK (ALCOHOL):

- Access to appropriate care: The Division has a need methodology which indicates how much of what type of service is needed in each county. The actual availability of services is evaluated against the need. Evaluation of the accessibility of services for special and underserved populations is part of the local services planning process conducted at the county level. Counties are expected to plan remedial actions when deficiencies are identified. The Division is mandated to assess the availability and utilization of services to women annually. In addition, the Division conducts various policy analyses regarding accessibility as needed.

- Waiting Lists: Waiting lists are an indication of a current demand for services in excess of the current-supply of services. However, waiting lists provide an incomplete picture of the unmet needs for services.

  a. When few program units are available to begin with, increasing the number of programs will increase the aggregated waiting list. In New York in a two-year period community residence beds were increased by

25 percent while waiting lists increased 100 percent. Since we are only meeting 16 percent of the need for community residences, there are not enough residences to generate a long aggregate waiting list. Patients don't wait for services that don't exist. Thus it is possible that a program to reduce waiting lists by increasing the number of treatment units may actually increase aggregated waiting lists.

b. Waiting lists must be integrated in terms of the type of program reporting a waiting list. Other things being equal, the longer the length of stay in a program, the longer the waiting list will be. Programs with a long length of stay need a waiting list so that an empty bed can be filled as soon as possible in order to maintain efficiency, i.e., high utilization rates. Waiting involves personal and social costs, but these costs may be relative to the expected length of stay. In contrast, a waiting list for emergency services is unacceptable.

c. A single individual may be on multiple waiting lists. This phenomena will increase as the unique number of individuals on waiting lists increases since individuals will seek admission at multiple treatment units when the likelihood of getting into any one soon is small. This is a source of bias in a waiting list indicator that is positively associated with the length of the waiting list and results in an exaggeration of the problem beyond the true number of individuals waiting.

d. An unmaintained waiting list grows and grows. The more effort taken to maintain contact with individuals on the waiting list the more accurate, but smaller the waiting list will be. This is a source of bias in the waiting list indicator that is positively associated with the length of the waiting list and results in an exaggeration of the problem. The Division controls this source of error by requiring that programs contact persons on the waiting list to ensure that they are still waiting before they can be reported as being on the list more than 30 days.

e. Outpatient programs provide a complex set of services including screening and assessment services to clients never admitted for treatment.

Outpatient programs treat heterogeneous populations, including alcohol patients and significant others. A single waiting list statistic does not indicate who is waiting for what. Some outpatient programs in New York State have a policy of not putting anyone on a waiting list. Instead they may provide group educational services until treatment services can be provided. Outpatient treatment is the core component of the treatment system in New York. It is also the largest component. Regulations require that patients be treated as outpatients unless they are unable to remain sober without a more structured setting (or other exceptional criteria are met). A waiting list indicator of need may be biased against the outpatient modality.

f. Given the above considerations, a waiting list indicator would be a poor means of allocating resources at the State, county or program level. Waiting lists may be biased in favor of the predominant existing program modalities and don't necessarily point the way toward an effective and efficient continuum of care.

o Continuum of Care: The Division of Alcoholism and Alcohol Abuse has regulatory authority over the full continuum of care: hospital-based acute care (detoxification), non-hospital based primary care and crisis centers, outpatient treatment and rehabilitation, inpatient rehabilitation and community residences including recovery homes, halfway houses and supportive living programs. The full continuum is more, or less, available in each county of the State. Counties are responsible for planning and proposing funding to provide an adequate local system of alcoholism services. The State Agency provides various proportions of matching funds up to 100 percent for some program categories. The Division's certificate of need (CON) process requires needs to be established consistent with the Division's need methodology prior to approval for establishment or expansion of programming. Thus the continuum of care can be measured on a county by county basis based on the Division's model system.

Continuity of Care is more difficult to measure. To a great extent, continuity of care will depend on an available continuum of services. However, direct measurement of continuity of care requires tracking of individual patients. In New York this would require

tracking across agencies since no agency provides all the components of the continuum. The Division is in the process of establishing a client-based information system as part of the federal minimum data set project. However, the Division does not anticipate using client IDs unique across agencies. Several alternatives which provide a more indirect measurement of continuity of care will be utilized.

NEW YORK (DRUG):

- Federal waiting list reduction funds are authorized for one year only. This will present problems in FY 91.
- Community resistance to development of treatment facilities in particular neighborhoods remains a significant obstacle.
- The Federal Government must assume greater financial responsibility for drug abuse services. At present in New York State, Federal participation in support of local drug programs amounts to only 14% of the total expenditures.

NORTH CAROLINA:

- Service utilization/methodology and data are needed for more effective planning.
- Waiting lists exist due to limited service availability.
- Training and technical assistance is needed to address client matching issues.

NORTH DAKOTA:

- Treatment beds/slots are available, however; funding is not available to fully utilize the public and private sector potential.

OHIO:

- There is a waiting list of over 2000 persons requiring treatment services.

OKLAHOMA:

- Accurate measurement is difficult. We are currently utilizing estimated prevalence (5.6%) of alcohol/drug problems and estimated demand for treatment at 20%. We

are concerned that many of our mental health professionals are seeing alcohol/drug clients, but are not trained to identify or treat alcohol/drug problems. We are beginning intensive training efforts.

PENNSYLVANIA:

- Assessment of access to treatment services is being addressed by application to OTI for a waiting list reduction grant. The development of the application for this grant has identified high areas of need.

PUERTO RICO:

- Lack of funding and trained personnel are major problems related to treatment access.

RHODE ISLAND:

- The Rhode Island State Agency, based upon recommendations of the Drug Abuse Treatment and Intervention Plan for Rhode Island, is forming a treatment standards panel to address the issues outlined here. Any information available on such issues as length of stay, inpatient versus outpatient treatment, access to appropriate care, continuum of care, etc., would be much appreciated. Contact Kerry O'Neil, Division of Substance Abuse.

SOUTH CAROLINA:

- We have yet to develop criteria for defining waiting lists which can be uniformly applied by outpatient providers throughout the State. Hence, our data on waiting lists for outpatient treatment are unreliable.

SOUTH DAKOTA:

- Due to the rural nature of the State there are several areas which cannot support a comprehensive array of services. Only one program (at the State Hospital) has a waiting list--no IV drug users are or have been on the waiting list. The State has insufficient transitional care facilities for adolescents and is in the need of custodial care for adults.

TENNESSEE:

- In the continuum of care the prevention area is incomplete and limited from the primary level of identification, intervention and assessment.

TEXAS:

- In FY 1989, there were an average of 1159 adults and 190 youth per month on waiting lists. In FY 1988, there were 935 adults/month and 110 youth/month. The demands for services are so great that many programs quit have maintaining lists, since they cannot respond to needs as soon as possible. Also, no differentiation are made in types of addicts needing services, women, crack, etc.

UTAH:

- Some client populations if kept on a waiting list longer than 2-3 weeks lose interest in treatment. Waiting list information is a fairly unreliable indicator of need.

VERMONT:

- Access to treatment is often related to the availability of treatment beds without adequate consideration to outpatient availability. Vermont is pursuing shorter lengths of residential treatment, longer terms of community based follow-up, intensive outpatient treatment as an alternative to residential care and is moving to provide more group work in traditional outpatient settings.

VIRGINIA:

- Varying definitions of "waiting lists" exist among Virginia's treatment programs.
- Lack of funding for residential beds is a major problem.
- Lack of adequate numbers of certified therapists and clinicians for treatment programs is similarly a problem.

WASHINGTON:

- WAITING LISTS: one problem is which point in service to measure; i.e. the referring agency, the receiving agency; and if receiving, for clients on waiting list, or for length of wait for admitted clients. Each gives different data.
- ACCESS AND CONTINUUM: are controlled by the Assessment Centers which prepare the plan for continuum of placements in treatment, and aftercare.

WEST VIRGINIA:

- The entire issue of measuring a "waiting" list is of concern. Many programs do not record any contact until an appointment is kept, with an approximate 6 weeks to 2 months wait from the initial request for services until the first appointment. Many providers manage to schedule new clients by spacing appointments much further apart than is clinically sound. Other problems revolve around the issue of appropriate care, particularly near the client's home; and tracking clients as they move from one service element to another, particularly when these are located in differing geographic areas.

WISCONSIN:

- Inaccuracies in data are problems with some programs.
- Some programs don't collect waiting list information.

APPENDIX G

STATE NARRATIVE REPORTS OF PROBLEMS IN ACCESSING CARE FOR ALCOHOL AND/OR OTHER DRUG ABUSING PREGNANT WOMEN

PROBLEMS IN ACCESSING CARE FOR PREGNANT WOMEN
WHO HAVE ALCOHOL AND/OR OTHER DRUG PROBLEMS

ALABAMA:

- Geographic accessibility.
- Child care (other children).
- No combined medical and alcohol/drug treatment services for women.

ALASKA:

- Care for other children while mother is in treatment.
- Lack of appropriate facilities and staff to meet unique treatment needs of pregnant women.
- Isolated women, or limited contact, with drinking/drugging boyfriend/husband/father.

ARIZONA:

- Residential capacity for women pregnant or otherwise, needs growth.
- Specialized treatment capacity (e.g., cocaine abuse) needs development for pregnant clients.
- Providing child care while women are in treatment is a need.

ARKANSAS:

- Treatment facilities are reluctant to accept pregnant women in their third trimester due to limited medical support services.

CALIFORNIA:

- DRUG PROGRAM DIVISION
  - In California, between 53,000 to 67,000 births annually are estimated to involve prenatal alcohol and/or drug exposure. Drug and alcohol use by women, particularly women of childbearing age, is increasing rapidly. The needs of alcohol and drug

abusing women and their children are complex, with these families having greater socio-environmental needs than families usually served by health and welfare programs. Because of the rapid escalation of this problem, the current capacity of alcohol and drug treatment programs is inadequate to meet the growing demand for services to pregnant and parenting women. For instance, we can document less than twenty programs statewide that accept women in residence with their children. Moreover, the services needed by this population, when they do exist, may be fragmented and without coordination.

- o ALCOHOL PROGRAM DIVISION

  - Not enough women specific services, i.e., residential recovery services, child care for women in residential recovery.

  - Existing programs for women are not physically equipped for pregnant women.

  - Program staff(s) are not adequately trained to handle pregnancies.

COLORADO:

- o Lack of special procedures and training for staff in both treatment settings and prenatal/post partum settings.

- o The potential for pregnant women to be charged with child abuse when using drugs.

- o Programs don't want to take pregnant clients because of liability issues and related costs for insurance coverage.

- o Most programs lack appropriate training and services to adequately treat pregnant clients and their babies.

CONNECTICUT:

- o Women are under-represented in alcohol and drug treatment programs. Stigma around being female and addicted still exists. Community gate keepers (e.g., lawyers, police, mental health workers) seem less likely to identify substance abusing women and, therefore, women are less likely to be referred to treatment. When women finally

do seek treatment, there may be a lack of available child care or acceptable child care alternatives and a lack of residential and outpatient treatment and rehabilitation programs focusing on women's issues.

DELAWARE:

- Conditions at some treatment programs make it very difficult for pregnant women to access care. Child care remains a chronic barrier to care for women.

DISTRICT OF COL.:

- An increasing number of pregnant women use cocaine, and, treatment programs are limited for this population.
- Inpatient treatment programs are limited and do not have the capability for treating women with children.
- Women continue to fear the legal implications for substance abusing parents and, therefore, avoid the public treatment system.
- Treatment costs in the private sector are prohibitive and they tend to reject pregnant addicted women.

FLORIDA:

- Waiting lists are a problem for all populations. Pregnant women have been made a priority for treatment in Florida, however. Specialized programs designed specifically for pregnant women in the past have been a problem. This year the dollars (federal ADAMHA block grant) are being utilized for specialized programming. Child care and transportation make it difficult for some women to get treatment. Additionally, some women fear prosecution and are less likely to present themselves for treatment.

GEORGIA:

- Lack of resources for, or unwillingness to assume medical responsibility for high risk pregnancy, for pre-natal and delivery costs.
- Lack of resources to provide child care for existing children.
- Lack of resources for outreach to pregnant women; lack of resources for specialized services such as parent training for addicted mothers.

HAWAII:

- 1) There are no specialized treatment programs for women who are pregnant; 2) Limited resources -- there are only two female-only treatment programs; and 3) Lack of awareness of treatment needs and resources in medical community.

IDAHO:

- Probably the biggest problem is the initial determination that a pregnant women has a substance abuse problem. Once that has been determined, most treatment programs can provide care. Often, prenatal care does not include key questions about substance use. Low income women will have difficulty in accessing good prenatal care. In some cases, if these women are in substance abuse treatment programs, the program will make a referral to community health clinics who are set up to treat low income people.

ILLINOIS:

- Within the female treatment population there exist populations with additional risk factors, needs, and programming requirements. Female intravenous drug users are at increased risk for transmission of the AIDS virus to their unborn children. Perinatal addiction and related birth defects associated with cocaine, heroin, and alcohol use have documented effects such as low birthweights, fetal neurological impairments-abnormalities, and varying degrees and types of birth defects. Substance abuse when treated results in positive outcomes for both the mother and child - left untreated both remain at risk.

INDIANA:

- Limited funding to support medical cost components of care.

KANSAS:

- In fiscal year 1989, 7,032 women age 15-44 were admitted to alcohol and drug treatment in Kansas. This figure represents roughly 1-2% of Kansas women of childbearing age. Yet national prevalence data from the 1988 National Household Survey indicate that 9% of women 15-44 years of age have used an illicit drug in the past month. Applying this prevalence figure to Kansas would mean that about 51,000 women of childbearing age used an illicit drug in the past month.

- Reports from hospital staff in Kansas City indicate that 10-15%, possibly as many as 40% of the pregnant women they see have abused some form of drug during pregnancy with about half of these admitting to cocaine use or having a positive urine screen for that drug. A Wesley hospital social worker in Wichita reports one delivery per week to mothers who used cocaine during pregnancy. Physicians at Kansas University Medical Center in Kansas City report that they regularly see pregnant women who use cocaine. The number of newborns with crack using mothers has jumped from one every other month to as many as eight a month. Most physicians agree that these figures are probably only the tip of the iceberg.

- Personnel in metropolitan health departments and social services offices are reporting significantly increased numbers of confirmed and suspected cases of alcohol/drug use in women they serve.

- Treatment providers report serious concerns about treatment capacity due to rapidly increasing numbers of drug using women, the intensity and complexity of their needs, concern for liability issues, and lack of system support for services to include adequate financing.

- Health Department staff raise a number of issues: lack of prioritization of treatment services for alcohol/drug using pregnant women; identified women placed on waiting lists; lack of staff training to identify and refer women who may be using alcohol or other drugs; increased numbers of women who report drug use, especially crack, during pregnancy; shortage of staff time to attend to the multiple needs of these women; lack of services integration by local providers; lack of awareness among women about deleterious effects of alcohol/drug use on their infants; and removal of children to foster care.

KENTUCKY:

- Kentucky does not have any programs designed to specifically meet the needs of this population. Waiting lists for residential programs and halfway houses are lengthy for both men and women.

LOUISIANA:

- Standard inpatient and outpatient treatment programs in Louisiana do not have special medical programs to provide the additional services needed by pregnant women. Treatment programs need to be closely coordinated with

primary health programs to ensure appropriate pre-natal services. Louisiana is in the process of staffing treatment programs with case managers and this could be a function in their job assignments.

MAINE:

- Waiting lists in residential programs.
- Child care problems for pregnant moms with kids.
- Lack of sufficient programs to provide specialized services to women in general.

MARYLAND:

- Access to and provision of outpatient services for pregnant women is not problematic. However, there is a lack of residential facilities able to provide services to both mother and child after the child is born. Unwilling to be separated from their newborn infants, many women leave treatment prematurely.

MASSACHUSETTS:

- Treatment program resistance to admission based on: lack of trained staff; ob/gyn back-up; fetal monitors; child care for other children; ability to maintain pregnant clients in care until after birth (through post partum).

MICHIGAN:

- In Michigan, there is only one program that is specifically designed to provide substance abuse treatment, counseling and rehabilitation services, methadone, child care/treatment and prenatal care to women and their children. Transportation to and from this program is often difficult, even for those residing in the city of Detroit. Women living outside the city are unable to access this type of care. In addition, there is great reluctance on the part of the medical field to treat pregnant addicts due to liability issues.

MINNESOTA:

- Most treatment programs do not have the capability of providing services to children. Whether the woman is pregnant or not, mothers often find it very difficult to find appropriate care for their children while in

treatment. This is particularly true when the mother is on some type of public assistance program which has limited funds available for day care.

- A second key issue is that by entering treatment women often risk losing their children to out-of-home placements such as foster care and find it very difficult to get their children back upon completing treatment.

- Current law in Minnesota state that a pregnant women who uses chemicals can be charged with child abuse/neglect. The law requires a number of health care professionals to be mandatory reporters. This law tends to prevent women who need help from seeking needed services for fear of being legally charged with child abuse and neglect.

- Minnesota has used some of its block grant funds this year to develop three demonstration programs that have the capability of providing services to women and their dependent children. Many of the hospital-based chemical dependency programs that have maternity wards can also provide limited services but the daycare problem is still an issue.

MISSISSIPPI:

- Some treatment programs are concerned about liability issues involving the pregnancy.

MISSOURI:

- Adequate child care for other children; adequate pre- and post-natal care; fear of retribution; limited capacity for women without financial resources; lack of coordinated training and referral relationships between women's centers and health care.

MONTANA:

- The greatest problems are appropriate and affordable child care and outreach.

NEBRASKA:

- All persons desiring services can receive care, however there are no specialty services for pregnant women.

NEVADA:

- We have not specifically studied the problems of pregnant women who seek treatment. It seems that pregnant women,

at a minimum, would share the same problems as other women. They would also have the added problem of finding child care for older children.

NEW HAMPSHIRE:

- There are presently no specialized facilities in New Hampshire offering treatment to pregnant women without insurance or financial resources. Detoxification services are also very difficult to access, because of the limited number of medical facilities willing or able to provide the service to indigent clientele. An additional problem concerns the provision of residential treatment services to pregnant women who have other children but no viable options to provide for their care while the mother is in treatment.

NEW JERSEY:

- Concern for ensuring the health of the fetus is a major issue, especially for pregnant women undergoing detoxification in residential or outpatient programs; and those in the last trimester. Availability of specialized medical services, including heart monitoring with a fetascope, constitute important diagnostic aids.

NEW MEXICO:

- Specialized care for this population is not available. The State is currently collecting data to identify the extent of problems and service needs.

NEW YORK - (ALCOHOL):

- There are insufficient services for women in general, and for pregnant women in particular.

- Programs may avoid providing services to pregnant women because they are concerned that: (1) they lack the medical expertise to adequately care for pregnant women; (2) their legal ability will be increased; and (3) pregnant women will leave the program as soon as they give birth.

- Pregnant women are often reluctant to enter treatment even when it's available because of: (1) fear that their children will be taken away from them; (2) denial that alcohol is a problem for them; and (3) lack of information about alcohol's impact on the fetus.

NEW YORK - (DRUG):

- There is an urgent need to develop more specialized treatment programs for pregnant women, post partum women and their children. See treatment issue report No. 67 which describes the extent of this problem in New York State.

NORTH CAROLINA:

- There is a paucity of services for women; a lack of professionals trained to serve this population; professional reluctance to handle the difficulties involved; and an inability to recognize symptomatology of substance use/abuse.

NORTH DAKOTA:

- A lack of information on treatment availability exists.

OHIO:

- Not all of the Alcohol, Drug Addiction and Mental Health Services Boards will provide these services within their service areas. Each board however, is expected to identify and address the needs in each local community within the parameters of their fiscal constraints. The increasing incidence of drug exposed infants, i.e., women abusing drug and/or alcohol during pregnancy, indicates a need for more outreach activities to this population.

OKLAHOMA:

- Providers are reluctant to admit pregnant women because of perceived risks. We are seeking training and requesting funds for specialized treatment.

OREGON:

- Specific treatment programs structured to meet the needs of addicted pregnant women and their families are few and far between. We have a five year waiting list in existing facilities.

PENNSYLVANIA:

- Addicted women do not actively seek prenatal care. Outreach services are being developed.

PUERTO RICO:

- Same as for other clients.

RHODE ISLAND:

- Problems include lack of knowledge or resources and lack of coordination between "health care" and "substance abuse" systems; lack of child care for women in treatment (residential and outpatient); transportation problems; women seeking substance abuse treatment late in pregnancy (substance abuse providers fearful of medical complications or "what to do" with newborn if woman continues treatment post-partum); and fear of losing custody of children prevents women from seeking substance abuse treatment.

SOUTH CAROLINA:

- Increasingly, law enforcement and child protective services authorities are using maternal drug use as grounds for termination of parental rights and/or criminal prosecution. This works as a deterrent to voluntary treatment entry.

SOUTH DAKOTA:

- Fetal Alcohol Syndrome (FAS) continues to be a significant problem especially on Indian reservations where outreach and other services are thin. We need, at Federal and State levels, better coordination between responsible agencies.

TENNESSEE:

- State funded programs for the most part are inadequately prepared to deal with the perinatal needs - no program exists in the State specifically for this population with the exception of one Methadone program. Basically we need to explore coordinating alcohol and drug programs with clinics and health departments, to deal with the special needs due to pregnancy.

TEXAS:

- Problems include: (1) concerns with regard to losing custody of children; (2) lack of sufficient professionals trained in substance abuse and pregnant women; (3) stigma and stereotyping of pregnant chemically dependent women; and (4) overall high mortality for neonatals and lack of prenatal care for low-income women in Texas.

UTAH:

- Many barriers exist that make it difficult for pregnant women to receive treatment. Many of these are similar to those for women in general, with the added medical concerns associated with pregnancy. Certainly low income levels, waiting lists, multiple sites for multiple problems, lack of child care and transportation, and lack of hospital detox are among the major barriers. One needed service is "one stop shopping" for counseling and medical services.

VERMONT:

- Need to intervene earlier through public health nurses, pediatricians, etc.
- We also need to identify residential treatment beds for pregnant women and women with young children.

VIRGINIA:

- There exists a limited number of substance abuse prenatal and parental care programs.
- Problems exist in identifying those substance abusing, pregnant women in need of services.
- Lack of adequately trained physicians and other staff to serve substance abusing pregnant women is a major problem.
- Lack of transportation services and child care services for pregnant substance abusing women are problems.

WASHINGTON:

- The 1989 State Legislature passed Washington's Omnibus Drug Act, which included funding for adolescent treatment, drug involuntary detention, and a broad range of treatment services for pregnant and post partum women. Problems still remaining include transportation to outpatient treatment, and to child care facilities for mothers in outpatient treatment. While funding is available for case finding and case management for pregnant women, we have experienced difficulty in finding enough case finders and case managers in a timely fashion.

WEST VIRGINIA:

- There are limited treatment alternatives for women, particularly for residential treatment and detoxification. Due to lack of funds for specialized staff, there is limited outreach and early identification; therefore, women tend to wait until the situation is critical, necessitating more intensive treatment.

- Women in treatment are handicapped by lack of transportation, child care alternatives, and vocational training opportunities. The problem of accessing care for women in the State is intensified by the low educational level in the State, and the lack of understanding of the problem.

WISCONSIN:

- Some programs are afraid of liability.

- Cost of treatment is high.

- Waiting lists are long in some areas.

APPENDIX H

STATE NARRATIVE REPORTS ON RELEVANT INFORMATION ON CHILDREN BORN TO WOMEN WHO USE ALCOHOL AND/OR OTHER DRUGS DURING PREGNANCY

INFORMATION ON ALCOHOL AND OTHER DRUG EXPOSED BABIES

CALIFORNIA:

DRUG PROGRAMS DIVISION

- California Department of Alcohol and Drug Programs; preliminary fact sheet on perinatal drug and alcohol use.
- Services for Alcohol and Drug Abusing Pregnant and Parenting Women and Their Infants. Guidelines for submitting a pilot project plan.
- California State Department of Alcohol and Drug Programs. Perinatal projects and related activities
- Drug Abuse Series: Cocaine Use and Pregnancy.

CONNECTICUT:

- This agency does not collect data on children born to women who use alcohol and/or drugs during pregnancy.

DELAWARE:

- No statewide data is available. The Medical Center of Delaware has 6,000 deliveries each year and 10% of the mothers test positive for some drug.

FLORIDA:

- The State Agency estimates that the number of substance abused newborns in Florida during the 1990-91 fiscal year will total 11,359. These figures include 7,959 cocaine babies (newborns estimated to test positive for cocaine), another 1,477 cocaine involved newborns (those who test negative, but have a maternal drug history of cocaine use), and another 1,923 babies affected by other drugs.

HAWAII:

- Substance abuse is the most commonly missed of all obstetrical and neonatal diagnoses.
- The majority of substance using pregnant women in Hawaii are not being identified: a retrospective study of hospital delivery records at Kapiolani hospital shows fewer than 100 women identified over the last two and half years. Over 70 of these were identified in the last year alone.

- Eleven percent of Hawaii's annual births could result in over 2,000 drug-affected infants each year. Even if our rate is HALF that of the Nation, we would still have over 900 drug-affected births each year.

- If Hawaii has the same rate of babies born with alcohol related effects, we can expect to have almost 100 infants each year requiring special services because of maternal alcohol use.

- Identified use of substances by pregnant women prior to and at time of delivery has more than doubled in the last year in the State of Hawaii. In the first 6 months of FY 1989, 2 referrals per week were made to Child Protective Services for substance use identified at birth; in the last 6 month period, between 4 and 6 referrals were made.

- Smoking of the drug crystal methamphetamine appears to be unique to the State of Hawaii and along with cocaine/crack appear to be the drugs of choice. While less is known regarding the effects of crystal methamphetamine on pregnancy, the evidence strongly suggests it to be equally and possibly more addictive than cocaine.

- Failure to access any treatment services, be it for prenatal care or drug rehabilitation, is the foremost issue for this population. Over 70% of the identified substance using pregnant women at Kapiolani Medical Center during the last year received late or no prenatal care.

- Hawaii currently has fewer than 50 chemical dependency treatment slots for women, both outpatient and residential. This is far less than the conservative estimate of 900 women in need.

- Once identified, these infants must receive comprehensive follow-up services. For those infants in a healthy start covered geographic area, such services would be available; however, not all parts of the State are at present served.

MASSACHUSETTS:

Title: Identification and Prevention of Fetal Alcohol Syndrome

Authors: Henry L. Rosett, M.D., Lynn Weiner, M.P.H., Barbara A. More, Ph.D., Division of Psychiatry, Boston University School of Medicine

Publication: Fetal Alcohol Education Program

No. of Pages: 14

MICHIGAN:

- The State submitted a Public Health News press release which it issued on September 12, 1989 which included the following statements:

"According to research using a new experimental technique to measure dug use during pregnancy, 42.7% of infants born at an urban Michigan hospital, from a statistically valid sample of 576 women, have been exposed to cocaine, heroin, or marijuana at some time during pregnancy. Forty percent (40%) of the infants showed evidence of cocaine or heroin exposure. State Health Director Raj M. Wiener announced these preliminary findings of a study supported by the Department of Public Health, carried out by Dr. Enrique Ostrea, Jr., chief of pediatrics, Hutzel Hospital Detroit...

"Dr. Ostrea's study, based on laboratory analysis of meconium (infant stool), included testing for cocaine, morphine derivatives (including heroin), and cannabinoid (marijuana). The methodology detects the presence of these drugs and indicates that the infant was exposed to them through the mother sometime during the pregnancy. The results reflect the presence of drug use but do not measure whether the mother was a heavy or an occasional user...

"Despite the need for more information as to the extent and nature of the impact of substance abuse on pregnant women and their infants, the problem demands immediate action. "We must make sure every pregnant women in Michigan knows that even casual drug use may be harmful

to her infant," said Wiener. "We must also step up our efforts to reach high risk pregnant women and bring them into prenatal care early so that we can identify possible drug use or abuse."

"Unfortunately, the health care system is not well equipped to handle this problem now. Drug treatment programs are not yet prepared to deal with complications of pregnancy or for women in general. Many women have other children and cannot easily make arrangements for child care when they enter a drug treatment program, said Wiener. The Eleonore Hutzel Recovery program, which is set up specifically to combine prenatal care with drug treatment, is outstanding. Unfortunately it is the only program in the State. We will be working with Donald Reisig, Drug Czar, and the Office of Substance Abuse Services over this year to expand this kind of service both in Detroit and elsewhere in the state," said Wiener. If you should have any further questions please contact Denise Holmes, Chief of the Bureau of Community Services at (517) 335-8955."

MINNESOTA:

- Of the 29 deaths in 1989 with cocaine use listed as an "other significant condition", 4 were stillborns and 4 were young infants ranging in age from 1 minute to 10 weeks. In these 8 cases, maternal use of cocaine was noted as an "other significant condition." Seven of these 8 deaths were black infants.

- A research study on the incidence of substance abuse among pregnant women was recently conducted utilizing blinded urine specimens of 1,800 women presenting at 9 metro hospitals for labor and delivery, and 400 women receiving prenatal care at 2 public clinics. Overall 2.2 percent of the specimens showed evidence of cocaine use (48 of the 2,200 pregnant women in the study). An interesting pattern appears when examining the labor and delivery data by type of hospital. Cocaine was more likely to be found among delivering mothers at public (vs. private) hospitals (7.2%), followed by public/ private hospitals (1.0%), and was less prevalent at the private hospitals (0.4%). At the public prenatal clinics studies, 2.8 percent tested positive for cocaine (11 out of 400).

- The survey of 2,200 pregnant women found that overall 7.4 percent tested positive for THC (164 out of 2,200). The highest percentage was found among the sample of 400

women receiving prenatal care at two public clinics (15.8%). At the public hospital labor and delivery sites 13.5 percent tested positive (54 out of 400), and at the public/private hospital labor and delivery sites 4 percent tested positive for THC (16 out of 400). Similar to the results concerning cocaine, the lowest percentage of positive samples for THC was found at the private hospital labor and delivery wards. Thirty-one of 1,000 of the urines tested there (3.1%) were positive for THC.

- The survey of 2,200 pregnant women in the metro area found no cases in which amphetamines were present.

NEVADA:

- A number of telephone calls were made to various entities: State Health Division; State Vital Statistics; State Health Resources and Cost Review: University of Nevada, Reno, Medical School, and Mental Health Institute disclosed the fact that no statistics were available to date on infants born with FAS and/or drug addiction.

- Therefore, the aforementioned survey was under-taken to determine the number of infants born in Nevada with FAS and/or cocaine addiction in 1988 since this is a growing national health care problem. In 1988 approximately 375,000 babies were born in the United States with drugs in their system.

A survey request was sent on September 18, 1989 to 25 of the 27 hospitals listed in the "Nevada Vital Statistics Report - 1987". The two facilities not contacted were Raleigh Hills and University Medical Center, Outpatient for they had not had any deliveries in a number of years. A second request was mailed on November 8, 1989, the following 5 hospitals had not responded:

HOSPITAL	AREA	NUMBER OF BIRTHS 1988
Grover C. Dill Hospital	Caliente	7
Nellis Air Force Base	Nellie	546
Nye General Hospital	Tonopah	26
St. Rose de Lima	Henderson	644
Washoe Medical Center	Reno	2,475
	TOTAL	3,698

According to state Vital Statistics the total number of births in Nevada in 1988 was 18,415. Of the 20 responding facilities the following statistics were obtained:

HOSPITAL	SEX	RACE	NUMBER	DRUG
Valley Hospital	F	Black	1	Cocaine
USPHS, Reno	F	Indian	1	Cocaine
USPHS, Schurz	F	Indian	1	Alcohol

TOTAL: (3)

Two of the hospitals provided the following comments:

- UMC: No statistics for 1988, however, approximately 11% of the 1990 infants have drug related problems.

- St. Mary's: Beginning in 1990 they will track drug addicted infants.

Of note, an article in the October 30, 1989, issue of the Reno Gazette Journal indicated that Washoe Medical Center will also start to track drug addicted infants in 1990.

It is unrealistic to believe that the survey results are accurate in light of the fact of known and documented statistics regarding the problem of substance abuse in Nevada. It is imperative that Nevada develop a statewide policy and procedure to annually track the number of FAS and drug addicted infants born in Nevada similar to the State's reporting policy for AIDS cases. Without such data, Nevada will be unsuccessful in procuring federal grant monies for the treatment and care of said infants and their mothers.

NEW YORK DRUG:

- Issue Report N. 67. "Children of Substance Abusers in New York State: Trends and Estimates."

OREGON:

- Oregon Health Division collects information on tobacco, alcohol and drug use by pregnant women on birth certificates starting 1/1/89.

PENNSYLVANIA:

- St. Francis Medical in Pittsburgh, PA has received a Federal grant to be the National Center for Substance Abuse Vulnerability.

RHODE ISLAND:

- Contact: Department of Health
  Maternal & Child Health Office
  Dr. William Hollingshead
  75 Davis Street
  Providence, RI 02903

TENNESSEE:

- Metropolitan Nashville-Davidson County has a population of 507,300 (U.S. Department of Commerce, Bureau of Census). In 1987 (the most recent year for which statistics are available), 8,157 births were recorded representing a birthrate of 16.4/1000 (Tennessee Department of Health and Environment Information Resources). Preliminary data from one local agency has provided insight regarding the scope of the problem of substance abuse among pregnant women in this area. The Maternal Infant Care (MIC) Clinic at the Nashville Metropolitan General Hospital, began routine drug screening with informed consent of all women entering their program in January 1989. Statistics from the MIC population include, a total of 356 patients who have been screened by interview and, after informed consent by a urine drug screen for cocaine, marijuana, and opiates. Ten percent of patients did not consent to the urine drug screen. Urine drug screens were positive for cocaine in 10% of patients; 11% were positive for marijuana, and 0.3% for opiates (Cartwright, 1989; Janofsky, 1989). These results are comparable to incidence reported by others (Frank, 1988; Little, 1988; Zuckerman, 1989). The efficacy of urine drug screens is strongly emphasized by the MIC data as 74% of the women with positive drug screens were assessed as being low or no risk based upon the substance abuse interview (Janofsku, 1989). Similar published studies report 16-24% of women who had a positive urine screen for cocaine or marijuana denied usage (Zuckerman, 1989; Frank, 1988). Further statistics from the Nashville General Hospital population revealed that 65% of documented substance abusers in 1989 were Black; 35% were White. The average age of Black substance abusers was 23 years; of White substance abusers was 27 years. All Black substance abusers and 73% Caucasian substance abusers were unmarried.

- Utilizing the MIC incidence of 11%, an estimated 915 babies will be exposed prenatally to cocaine or marijuana per year in Metropolitan Nashville-Davidson County. However, this statistic does not address the number of

prenatal exposures to alcohol. Based on the MIC data and the lack of a formalized screening program in other clinics, it is likely that the majority of such high risk pregnancies will not be identified prenatally.

- The Nashville Metropolitan Health Department (NMHD) through its three prenatal clinic sites provided prenatal care to 637 women in 1988. This population of women is similar to those followed by the MIC Clinic. Of the 218 patients served at one clinic site, 4% were under 15 years of age, 42%, 15-19 years, and 54% were over 19 years. Approximately 1% of these patients were identified as substance abusers based on self-report (Bureau of Nursing Services, Division of Maternal and Child Health).

TEXAS:

- Pharmacological consequences document.

VIRGINIA:

- Psychopathology in relationship to treatment acceptance, compliance and outcome: In order to fully comprehend the findings of treatment outcome studies for substance abusers, a number of variables need to be evaluated for their relative contribution to treatment success or failure. We are interested in ascertaining the impact of Axis I and Axis II psychopathology, particularly mood disorders and antisocial personality, on treatment acceptance, compliance and outcome. By identifying patients who respond well and those who respond poorly to traditional treatment techniques, we will be able to develop new strategies for more effective intervention and patient/treatment matching.

- Cocaine withdrawal and fetal stress and development: There is currently no accepted chemotherapy for cocaine abuse in pregnant women and it is generally accepted that precipitous withdrawal, if performed at all in the pregnant addict, should only be performed in the second trimester. Despite lack of evidence in well designed studies to support this belief, most practitioners assume that withdrawal during pregnancy will result in spontaneous abortion or premature labor. Currently, we do not know the relative benefits and risks to the fetus of gestational detoxification versus continuation of the offending substance. Positive outcomes in preliminary withdrawal studies have been observed; however, more work

is needed to study the effects of withdrawal during pregnancy on the mother and fetus. One goal of the CPA is to follow women withdrawn during pregnancy and evaluate neonatal behavior and development.

- Cocaine withdrawal and immune function: The stress of precipitous withdrawal can cause alterations in hormonal levels and neurotransmitter activity and the immune system is altered by changes in levels of stress and hormonal activity. It is therefore reasonable to believe that withdrawal from drugs may alter immune function and thus may be a cofactor in HIV spectrum disorder. These changes may be transient or, in the cases of repeated intoxication and withdrawal, more long lasting. The purpose of this investigation is to evaluate the effects of cocaine withdrawal on immune function.

- Effect of substance abuse and psychopathology on mother-infant relationships: One source of stress that is a critical problem for our target population is the dysfunctional mother-infant relationship. Children of addicts are at high risk to be neglected/abused and to become addicts themselves. It has been proposed that parenting deficits may lead to this "intergenerational effect". In order to identify target areas of clinical intervention, critical elements involved in the dysfunctional dyad will be evaluated. We will initially investigate the effect of the mother's drug use and psychosocial factors on parenting skills.

- Information that is available concerning the four research areas listed above include the initial proposal and project design. A detailed protocol and pilot data is available for protocol number one and the data are currently being analyzed. Detailed protocols for the other three research projects are presently being developed. Pilot-data collection for protocols two and three was scheduled to begin December 1, 1989. Data collection for protocol four was scheduled to begin February 1, 1990. Monthly reports are scheduled for each protocol. Following an approximate 6-month period for pilot data collection, final Manuals of Operation will be completed.

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WASHINGTON:

- We estimate that 7,000 pregnant women use some substance during pregnancy. 35% of the 7,000 use crack, which would put the number of women using crack at 2,450. Considering that all of the babies born to these women would be born affected, and probably 25% addicted, would put the number of crack addicted infants at 612. The average would be 51 per month. We have no data on heroin or methadone infant addictions.

WISCONSIN:

- Cocaine Babies

  Brief Description:

  There has been an epidemic of cocaine use in pregnant women in Milwaukee. There has been a dramatic increase in the number of child neglect cases because of this.

- Estimated Cost Dollars and Full Time Equivalent (FTE) Assumptions:

  $6,795,000; if this sounds costly, the initial hospitalization alone of a premature cocaine baby may cost up to $400,000. This does not cover long tern care often needed over the child's lifetime, including medical, educational, vocational and other costs.

  One FTE to coordinate the program.

- Why was 1989-91 too soon and why is 1991-93 too late?

  This was not a major problem until this year. It has grown dramatically. While Wisconsin does not collect systematic data, some hospital specific data is available. One Milwaukee hospital found that 4.5% (143) of the mothers of 3,141 babies delivered in 1988 reported using cocaine during their pregnancies. This compared to 1% in 1983. Substantially more babies, on the order of 10% to 15%, were likely to have been exposed to cocaine during their pregnancy because of underreporting.

  1993-93 is too late - low birth weight babies will cost more than this proposal is asking for.

60% on AODA waiting lists in Milwaukee have cocaine problems.

99% of family court cases are cocaine related.

- If we need to wait until 1991-93 budget, what steps will we need to take to make the delay tolerable?

  1. Make AODA services a priority for cocaine addicted women.

  2. Rechannel any existing DHSS funds into funding this issue.

  3. Try to get an exemption for using MA funds for prevention and intervention to this population.

  4. Make HMOs more aware of the problem and encourage them to address this problem, especially in the populations they are currently serving, i.e., low-income families.

  5. Allocate more resources for day care services for children from affected cocaine families.

  6. Tailor the Healthy Start Program in Milwaukee to pregnant women using cocaine.

- Contact Persons:

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